

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 will be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8804 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08770

Reg. Dist. No.

| | | | |
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| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN lb 1yr1mth18dys | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL | | d. STREET ADDRESS 1102 Webster Street | |
| 3. NAME OF DECEASED (Type or print) First Annie Middle Rose Last Adams | | 4. DATE OF DEATH Month August Day 28 Year 19 60 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED: <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 4, 1928 |
| 9. AGE (In years last birthday) 32 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) fortune teller | | 10b. KIND OF BUSINESS OR INDUSTRY Unknown | |
| 11. BIRTHPLACE (State or foreign country) U. S. A. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Robert Adams | | 14. MOTHER'S MAIDEN NAME Rose | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. unknown | |
| 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation by hanging from tree with rope DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) around the neck DUE TO (c) Suicide | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pt. found at 3:25 p.m. on 8-28-60, hanging from tree with rope around her neck | |
| 20c. TIME OF INJURY Month, Day, Year 3-25 P.M. 8-28-60 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital | | 20f. (City or town) (County) (State) Catonsville 28, Maryland | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <i>George M. Kieffer</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) George M. Kieffer, M. D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| DATE SIGNED 8-29-60 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF AUG. 30, 1960 | |
| 22c. NAME OF CEMETERY OR CREMATORY mt. OLIVE | | 22d. LOCATION (City, town, or county) (State) WASH | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W W Taltavull | | ADDRESS 3603 14th St NW | |
| 24a. REC'D BY REGISTRAR AUG 31 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kneiss | |

05770

STATE OF TEXAS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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1. Name of Deceased: _____

2. Sex: _____

3. Age: _____

4. Date of Death: _____

5. Place of Death: _____

6. Cause of Death: _____

7. Manner of Death: _____

8. Signature of Medical Examiner: _____

9. Signature of Coroner: _____

10. Signature of Physician: _____

11. Signature of Family: _____

12. Signature of Witness: _____

13. Signature of Juror: _____

14. Signature of Juror: _____

15. Signature of Juror: _____

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100. Signature of Juror: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | |
|---|--|---|---|---|--|--|--|--|--|
| 8805 CERTIFICATE OF DEATH | | | | | | | | | |
| Reg. Dist. No. 08771 | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LONG GREEN</u> | | | | | c. LENGTH OF STAY IN 1b <u>35 YEARS</u> | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 26 GLEN ARM P.O.</u> | | | | | e. STREET ADDRESS <u>Box 26 GLEN ARM P.O.</u> | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET ELIZABETH ALBRECHT</u> | | | | | 4. DATE OF DEATH Month Day Year <u>AUG. 30 1960</u> | | | | |
| 5. SEX <u>FEMALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>MAY 19, 1887</u> | | 9. AGE (In years last birthday) yrs. <u>73</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | |
| 13. FATHER'S NAME <u>HENRY L. BARBOUR</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>105-10-7525B</u> | | INFORMANT Address <u>CHARLES ALBRECHT, GLEN ARM P.O. BOX 26</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial degeneration</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Atherosclerosis + Cor. Arty Dis.</u> (c) <u>Arteriosclerosis gen. d.</u> INTERVAL BETWEEN ONSET AND DEATH <u>about 1 yr.</u> | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive Heart failure</u> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from <u>Mar 1960</u> to <u>Aug 1960</u> , that I last saw the deceased alive on <u>Aug 28, 1960</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>9005 Hartford Rd, Balto 14 Md</u> DATE SIGNED <u>8/30/60</u> | | | | | | | | | |
| ACTUAL SIGNATURE <u>FRANK T. KASIK</u> M.D. | | | | | DATE SIGNED <u>8/30/60</u> | | | | |
| PHYSICIAN'S NAME (Type) <u>FRANK T. KASIK</u> | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>SEPT 1, 1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE</u> | | 22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MARYLAND</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home 7401 Belair Rd. #6. Md</u> | | | | | 24a. REC'D BY REGISTRAR <u>AUG 31 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u> | | |

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CERTIFICATE OF DEATH

Reg. Dist. No.

08772

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| 1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANSOWNE</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>71 BALTIMORE COUNTY</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>913 WINSAP COURT</u> | | | | d. STREET ADDRESS <u>913 WINSAP COURT</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>HELEN</u> Middle <u>ALLEN</u> Last | | | | 4. DATE OF DEATH <u>Aug 7</u> Month <u>Aug</u> Day <u>7</u> Year <u>1960</u> | | | |
| 5. SEX <u>FEMALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>FEB. 14, 1895</u> 9. AGE (In years last birthday) <u>65</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (State or foreign country) <u>BALTO. MD.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>CHARLES STEWART</u> | | | | 14. MOTHER'S MAIDEN NAME <u>ANNA FORD</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u> | | 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT <u>MR. VERNON E. ALLEN</u> Address <u>913 WINSAP COURT</u> (27) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u> | | | |
| 20c. TIME OF INJURY Month, Day, Year <u>Aug 11, 1960</u> Hour <u>2:30</u> P.M. 19 <u>60</u> | | | | 20d. INJURY OCCURRED: White <input type="checkbox"/> at work <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office-bldg., etc.) <u>—</u> 20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u> | |
| 21. I certify that I attended the deceased from <u>April 11, 1959</u> to <u>August 6, 1960</u> that I last saw the deceased alive on <u>Aug 6, 1960</u> and that death occurred at <u>2:30 PM</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Florian P. Nadolski</u> | | | | ADDRESS (Street, city or town, state) <u>2703 Hawthornes Ford Rd Baltimore 27, Md</u> DATE SIGNED <u>Aug 8, 60</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Florian P. Nadolski</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Aug 10, 1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park Cem.</u> | | 22d. LOCATION (City, town, or county) <u>Balt.</u> (State) <u>MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>S. Truman Schuch</u> ADDRESS <u>3512 Frederick Ave. (29)</u> | | | | 24a. REC'D BY REGISTRAR <u>—</u> DATE <u>AUG 9 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

0104

0104

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| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES H. HARRIS | | M | | 45 | | JAN 15 1880 | | NEW YORK CITY | |
| RESIDENCE | | OCCUPATION | | CAUSE OF DEATH | | MANNER OF DEATH | | PLACE OF DEATH | |
| 1234 5th Ave | | Clerk | | Heart Disease | | Natural | | New York City | |
| DATE OF DEATH | | TIME OF DEATH | | HOUR OF DEATH | | MINUTE OF DEATH | | SECOND OF DEATH | |
| JAN 20 1920 | | 10:15 AM | | 10 | | 15 | | 00 | |
| PLACE OF DEATH | | OCCUPATION | | CAUSE OF DEATH | | MANNER OF DEATH | | PLACE OF DEATH | |
| New York City | | Clerk | | Heart Disease | | Natural | | New York City | |
| DATE OF DEATH | | TIME OF DEATH | | HOUR OF DEATH | | MINUTE OF DEATH | | SECOND OF DEATH | |
| JAN 20 1920 | | 10:15 AM | | 10 | | 15 | | 00 | |
| PLACE OF DEATH | | OCCUPATION | | CAUSE OF DEATH | | MANNER OF DEATH | | PLACE OF DEATH | |
| New York City | | Clerk | | Heart Disease | | Natural | | New York City | |
| DATE OF DEATH | | TIME OF DEATH | | HOUR OF DEATH | | MINUTE OF DEATH | | SECOND OF DEATH | |
| JAN 20 1920 | | 10:15 AM | | 10 | | 15 | | 00 | |
| PLACE OF DEATH | | OCCUPATION | | CAUSE OF DEATH | | MANNER OF DEATH | | PLACE OF DEATH | |
| New York City | | Clerk | | Heart Disease | | Natural | | New York City | |

0104

RECEIVED
JAN 21 1920
NEW YORK CITY

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CERTIFICATE OF DEATH

08773

Reg. Dist. No.

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| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall, R.D.</u> c. LENGTH OF STAY IN 1b <u>88 yrs.</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall, R.D.</u> d. STREET ADDRESS <u>1 Garrett Rd.</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>W.</u> Middle <u>Almon</u> Last <u>Y</u> | | | | 4. DATE OF DEATH Month <u>August</u> Day <u>2</u> Year <u>1960</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb. 25, 1872</u> | 9. AGE (In years last birthday) <u>88</u> yrs. | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Charles L. Almon</u> | | | 14. MOTHER'S MAIDEN NAME <u>Adeline Quigley</u> | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u> </u> | | INFORMANT <u>C. Franklin Almon</u> Address <u>Towson, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Breuche pneumonia</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardio Vascular disease</u> DUE TO (c) <u> </u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that I attended the deceased from <u>140</u> to <u>Aug 2</u> , 19 <u>60</u> that I last saw the deceased alive on <u>Sept. 9 1960</u> , and that death occurred at <u>12</u> PM, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>A. M. France</u> M.D. | | ADDRESS (Street, city or town, state) <u>PARKTON, MD.</u> DATE SIGNED <u>9/2/60</u> | | | | | |
| PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>8-5-60</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>West Liberty Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>White Hall, R.D., Maryland</u> | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Hartenstein, New Freedom, Pa.</u> | | | 24a. REC'D BY REGISTRAR <u>AUG 8 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit.

VS A15 (4)
15M 9/58

ESTD

ESTD 20 YEARS

1938

CHIEF OF POLICE

NEW YORK

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8807 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08774

FOR STATE HEALTH DEPT.

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY in lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 114 Stevenson Lane | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12 d. STREET ADDRESS 114 Stevenson Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First JEAN Middle GRAHAM Last ANDREAE | | 4. DATE OF DEATH Month August Day 25 Year 19 60 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 18, 1929 |
| 9. AGE (In years last birthday) 31 yrs. | | 10. IF UNDER 1 YEAR Months 31 Days 31 | 11. IF UNDER 24 HRS. Hours 31 Min. 31 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY at home | |
| 11. BIRTHPLACE (State or foreign country) Missouri | | 12. CITIZEN OF WHAT COUNTRY? Missouri | |
| 13. FATHER'S NAME Richard W. Gowdy | | 14. MOTHER'S MAIDEN NAME Ruth Graham | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no | | 16. SOCIAL SECURITY NO. - | |
| 17. INFORMANT Mr. C. Norman Andreae, Jr. - 114 Stevenson La. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Alcoholism (acute) 888.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Overdose of sleeping pills DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 2:00P | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Ingested sleeping pills while intoxicated. Terminal episode was aspiration of stomach contents. | |
| 20c. TIME OF INJURY Month, Day, Year 8/25/ 1960 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | | 20f. (City or town) (County) (State) nr. Balto. Balto. Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED August 26, 1960 | | | |
| ACTUAL SIGNATURE Wm. J. Tolener EXAMINER'S NAME (Type) | | M.D. Wm. J. Tolener | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/27/60 | |
| 22c. NAME OF CEMETERY OR CREMATORY Bruid Ridge Cem. | | 22d. LOCATION (City, town, or country) (State) Pikesville, Md. | |
| 23. FUNERAL DIRECTOR Wm. J. Tolener & Sons - Balto. Md. | | 24a. REC'D BY REGISTRAR AUG 29 '60 | |
| 24b. REGISTRAR'S SIGNATURE Wm. J. Tolener | | | |

MEDICAL CERTIFICATION

5082

2100

1-2

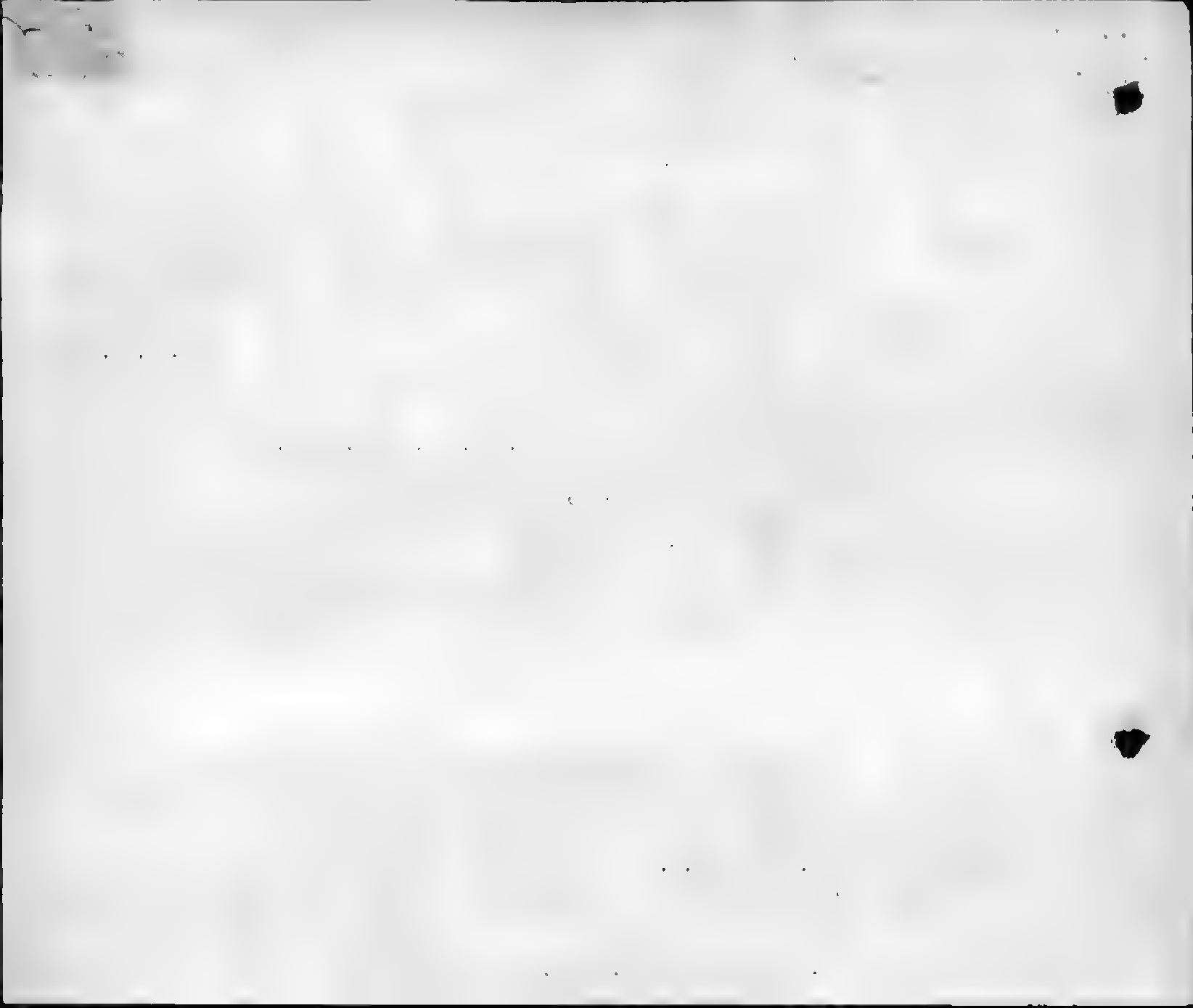
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **8775**

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 6 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 31 d. STREET ADDRESS 709 Van Lill Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First JACOB Middle -- Last ANDROCHEK | | 4. DATE OF DEATH Month August Day 11 Year 1960 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 13, 1894 |
| 9. AGE (In years last birthday) 66 yrs. | | IF UNDER 1 YEAR Months 0 Days 0 | IF UNDER 24 HRS. Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Odd Jobs | | 10b. KIND OF BUSINESS OR INDUSTRY Laborer | |
| 11. BIRTHPLACE (State or foreign country) Russia | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Phillip Androchek | | 14. MOTHER'S MAIDEN NAME Pearl Dirkach | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> WW I | | 16. SOCIAL SECURITY NO. WW I | |
| 17. INFORMANT Clin. Rec. VAH, Balto. 18, Md. Fort Howard Division | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FRACTURED SKULL, RIGHT PARAMEDIAN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SUB-DURAL HEMORRHAGE DUE TO (c) | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20. INTERVAL BETWEEN ONSET AND DEATH 11 Days | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CIRRHOSIS OF LIVER | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell & Struck Head on Pavement | |
| 20c. TIME OF INJURY Month, Day, Year Aug 1 1960 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street | | 20f. (City or town) (County) (State) Balto - Md. | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>. | | | |
| ACTUAL SIGNATURE MELVIN B. DAVIS, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8-16-60 | |
| 22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery | | 22d. LOCATION (City, town, or county) (State) Baltimore 28, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc. | | 24a. REC'D BY REGISTRAR DATE AUG 15 '60 | |
| 24b. REGISTRAR'S SIGNATURE C. L. L. L. | | DATE SIGNED 8/11/60. | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 may be retained for your files. Forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



8809

CERTIFICATE OF DEATH

Reg. Dist. No. 08776

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 31 | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural: Towson | | c. LENGTH OF STAY IN 1b 3 mos. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eudowood Sanatorium Towson 4, Maryland | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 142 N. Linwood Ave - Baltimore 24 d. STREET ADDRESS 142 N. Linwood Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Wesley Middle L Last Ashley | | 4. DATE OF DEATH Month Aug Day 11 Year 1960 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH May 13 - 1902 |
| 9. AGE (in years last birthday) 58 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 5 Days 8 Hours 0 Min 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY Social Security | |
| 11. BIRTHPLACE (State or foreign country) Baltimore Md | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13. FATHER'S NAME Charles Ashley | | 14. MOTHER'S MAIDEN NAME Mary M. Daniel | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No) no | | 16. SOCIAL SECURITY NO 220-09-0471 | |
| 17. INFORMANT Personal History | | Address Hospital Records, Eudowood Sanatorium | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma - Rt Lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 163X DUE TO (c) 4/26/60 - 8/11/60 | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 1960 to Aug 11, 1960 , that I last saw the deceased alive on Aug 12, 1960 , and that death occurred at 9 PM , from the causes and on the date stated above ADDRESS (Street, city or town, state) Eudowood Sanatorium DATE SIGNED Milton B. Kress | | | |
| ACTUAL SIGNATURE Milton B. Kress | | PHYSICIAN'S NAME (Type) Milton B. Kress, M.D. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 8-15-60 | |
| 22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery | | 22d. LOCATION (City, town, or county) (State) Baltimore | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, Inc., 1050 York Road, Towson | | 24a. REC'D BY REGISTRAR DATE AUG 15 '60 | |
| 24b. REGISTRAR'S SIGNATURE Arthur L. Grand | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

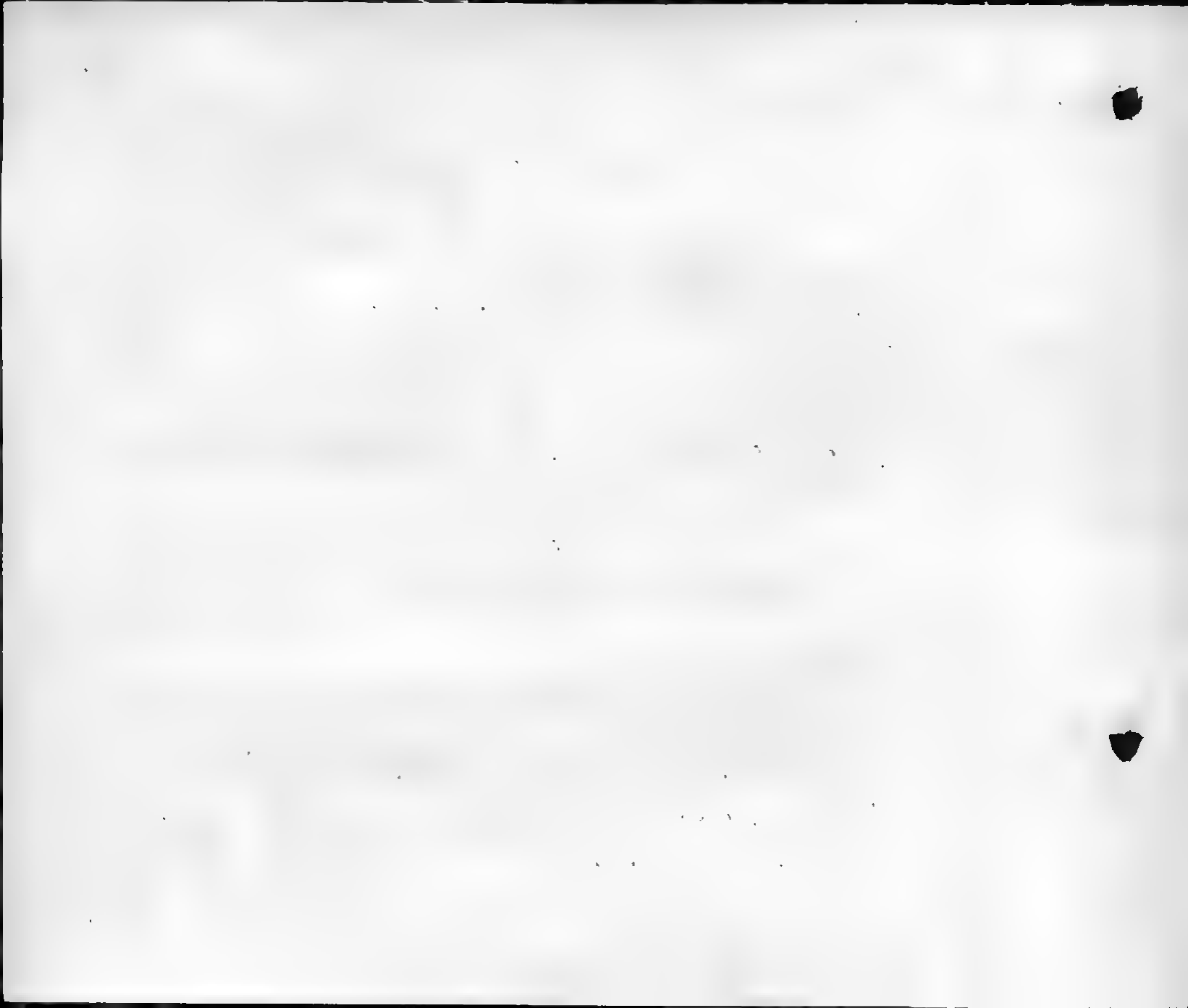
CERTIFICATE OF DEATH

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| | | | |
|---|----------------------------------|---|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton, Maryland | |
| d. NAME OF HOSPITAL (If not in hospital, give street address; OR INSTITUTION) SPRING GROVE STATE HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First Elizabeth Middle Ann Last Atkin | | 4. DATE OF DEATH Month August Day 9 Year 1960 | |
| 5 SEX female | 6. COLOR OR RACE white | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH Nov. 11, 1880 |
| 9 AGE (In years last birthday) 79 yrs | | 10 IF UNDER 1 YEAR Months 7 Days 10 Hours 10 Min 10 | 11 IF UNDER 24 HRS Months 7 Days 10 Hours 10 Min 10 |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b KIND OF BUSINESS OR INDUSTRY | |
| 11 BIRTHPLACE (State or foreign country) England | | 12 CITIZEN OF WHAT COUNTRY? England | |
| 13. FATHER'S NAME John Rodgers | | 14. MOTHER'S MAIDEN NAME Levina Rodgers | |
| 15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16 SOCIAL SECURITY NO None | |
| 17 INFORMANT Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21 I certify that (I) (this hospital) attended the deceased from June 2, 1960 , to Aug. 9, 1960 , that (I) (we) last saw the deceased alive on Aug. 9, 1960 , and that death occurred at 3:40 P.M. from the causes and on the date stated above | | | |
| 22a SIGNATURE Stella Wachslar | | 22b DATE SIGNED 8-9-60 | |
| 22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. | | 22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland | |
| 23a BURIAL, CREMATION, OR REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 8-11-60 | |
| 23c. NAME OF CEMETERY OR CREMATORY Parkwood | | 23d. LOCATION (City, town, or county) (State) BALTO. CTY., Md | |
| 24 FUNERAL DIRECTOR'S SIGNATURE George Schwan | | 25a REC'D BY REGISTRAR Aug 11 '60 | |
| 25b REGISTRAR'S SIGNATURE John S. Kline | | | |

MEDICAL CERTIFICATION

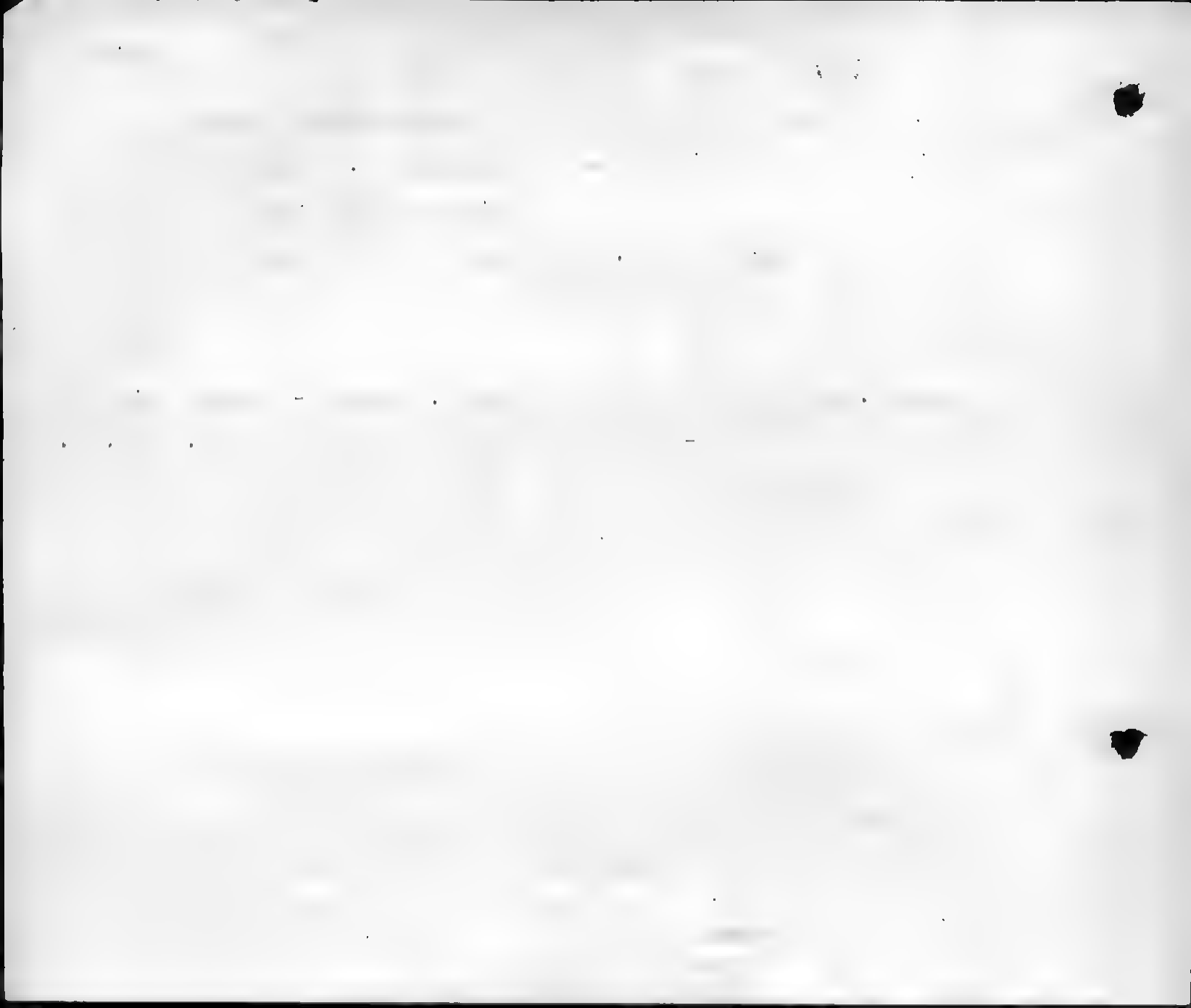


A15 (4)
9/59

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| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore County | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Baltimore County, Maryland | | b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville | | c. LENGTH OF STAY IN To 4 yrs | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville, Md. | | d. STREET ADDRESS 1010 Scotts Hill Drive | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Charles A. Ball | | First Middle Last | | 4. DATE OF DEATH August 21 1960 | | Month Day Year | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH June 12, 1912 | |
| 9. AGE (In years last birthday) 48 yrs | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) District Supervisor | | 10b. KIND OF BUSINESS OR INDUSTRY Gas & Oil | | 11. BIRTHPLACE (State or foreign country) Ohio | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Ernest I. Ball | | 14. MOTHER'S MAIDEN NAME Lola M. Mulberth - Columbus, Ohio | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | |
| 16. SOCIAL SECURITY NO. 291-07-5994 | | 17. INFORMANT Jo-Ann Ball | | 18. 1010 Scotts Hill Dr. Pikes. Md. | | 19. ADDRESS | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 416X Coronary Thrombosis DUE TO (b) Rheumatic Heart Disease, decomp. DUE TO (c) 5 yrs | | INTERVAL BETWEEN ONSET AND DEATH 20 min | | PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 21. I certify that (.) (this hospital) attended the deceased from Feb 26 1960 to Aug 21 1960 that (I) (we) last saw the deceased alive on Aug 5 1960 , and that death occurred at 6:25 M. from the causes and on the date stated above | | 22a. SIGNATURE Randolph H. Spitzberg M.D. | |
| 22c. PHYSICIAN'S NAME (Type) RANDOLPH H. SPITZBERG, MD | | 22d. ADDRESS 3806 Falls Koff Rd 15, Md | | 22b. DATE SIGNED Aug 21, 1960 | | 22c. DATE SIGNED | |
| 23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8-24-1960 | | 23c. NAME OF CEMETERY OR CREMATORY Sunset Cemetery | | 23d. LOCATION (City, town, or county) (State) Columbus, Ohio | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Long & Sons | | 25a. RECEIVED BY REGISTRAR DATE AUG 23 '60 | | 25b. REGISTRAR'S SIGNATURE Wm. L. Knead | | 25c. REGISTRAR'S SIGNATURE | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

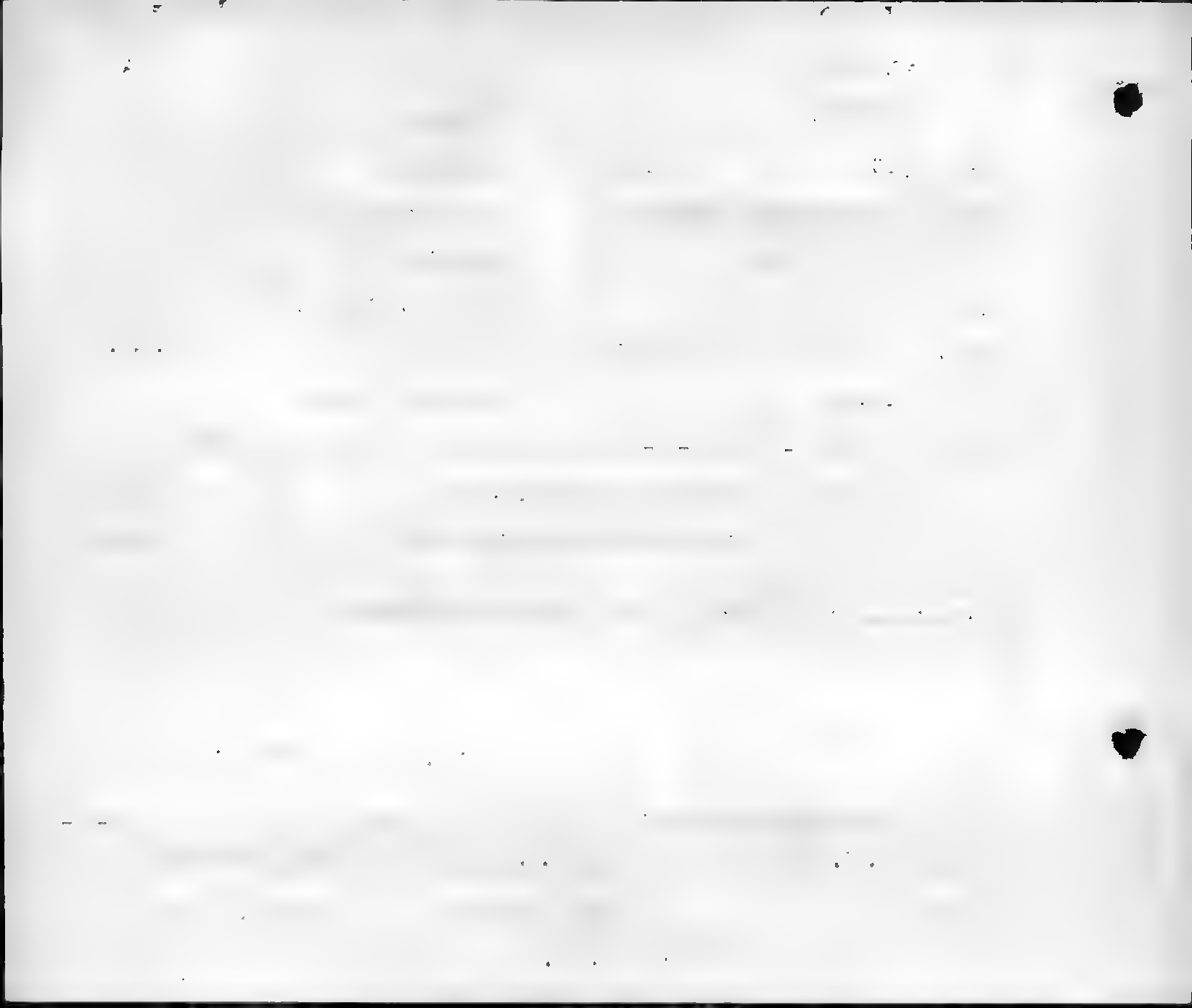
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1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY V | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | | | c. LENGTH OF STAY IN 1b 45 DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL | | | | e. STREET ADDRESS 3710 DELVERNE ROAD | | | |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle F Last BARNARD | | | | 4. DATE OF DEATH Month AUGUST Day 20 Year 1960 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH DECEMBER 19, 1880 | |
| 9. AGE (in years last birthday) 79 yrs | | 10. F. UNDER 1 YEAR Months 7 Days 19 Hours 15 Min. | | 11. BIRTHPLACE (State or foreign country) PENNSYLVANIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10a. USLA. OCCUPATION (Give kind of work done during most of working life, even if retired) MECH. ENGINEER | | | | 10b. KIND OF BUSINESS OR INDUSTRY DISTILLERY | | | |
| 13. FATHER'S NAME JOHN BARNARD | | | | 14. MOTHER'S MAIDEN NAME MARGARET SLAUGHTER | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES | | | | 16. SOCIAL SECURITY NO 185-07-6122 | | 17. INFORMANT CLIN REC VAH BALTO MD FT HOWARD DIV | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARRHYTHMIA, ACUTE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE (c) UNKNOWN | | | | INTERVAL BETWEEN ONSET AND DEATH UNKNOWN | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Colon With Hepatomegaly due to Metastasis | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hosp'tal) attended the deceased from July 6, 1960 to August 20, 1960 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 20, 1960 and that death occurred at 11:40 AM , from the causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE <i>L. B. Smith</i> | | | | ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 8-20-60 | |
| 22c. PHYSICIAN'S NAME (Type) L. B. SMITH | | | | 22d. ADDRESS M.D. VAH BALTIMORE MD Ft Howard Div | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | | 23b. DATE THEREOF 8-23-60 | | 23c. NAME OF CEMETERY OR CREMATORY NEW HARMONY CEMETERY | | 23d. LOCATION (City, town, or county) (State) NEW HARMONY, INDIANA | |
| 24. FUNERAL DIRECTOR'S SIGNATURE FARLEY FUNERAL HOME | | | | 25a. REC'D BY REGISTRAR 6601 FREDERICK AVENUE CATONSVILLE 28, MD. | | 25b. REGISTRAR'S SIGNATURE <i>Arthur S. K...</i> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8813
Certificate of Death
Item 9 Baltimore, Md. 24-00 et
08780

| | | | |
|--|-------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION College Manor | | d. STREET ADDRESS 220 W. Lanvale St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Dr. Ernest J. Becker Middle Last | | 4. DATE OF DEATH Month August 21 Day Year 19 60 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 9, 1875 |
| 9. AGE (In years last birthday) 85 yrs | | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Professor | | 10b. KIND OF BUSINESS OR INDUSTRY School | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Henry Becker | | 14. MOTHER'S MAIDEN NAME Clara Muller | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO | |
| 17. INFORMANT Mrs. Mary Ditty 1307 Park Ave. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 144X IMMEDIATE CAUSE (a) Cancer of mouth & metastases DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cerebrovascular Disease | | INTERVAL BETWEEN ONSET AND DEATH 8 mos | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Aug. 21, 1960 to Aug 21 1960 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 9 A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE William F. Fritz M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type) WILLIAM F. FRITZ | | 22b. ADDRESS 24 UNIVERSITY PKWY | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8-24-60 | |
| 23c. NAME OF CEMETERY OR CREMATORY Louisa Park | | 23d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons, Inc. 1900 Rutaw Place | | 25a. REC'D BY REGISTRAR AUG 24 '60 25b. REGISTRAR'S SIGNATURE William S. Kuntz | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. For page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9-59

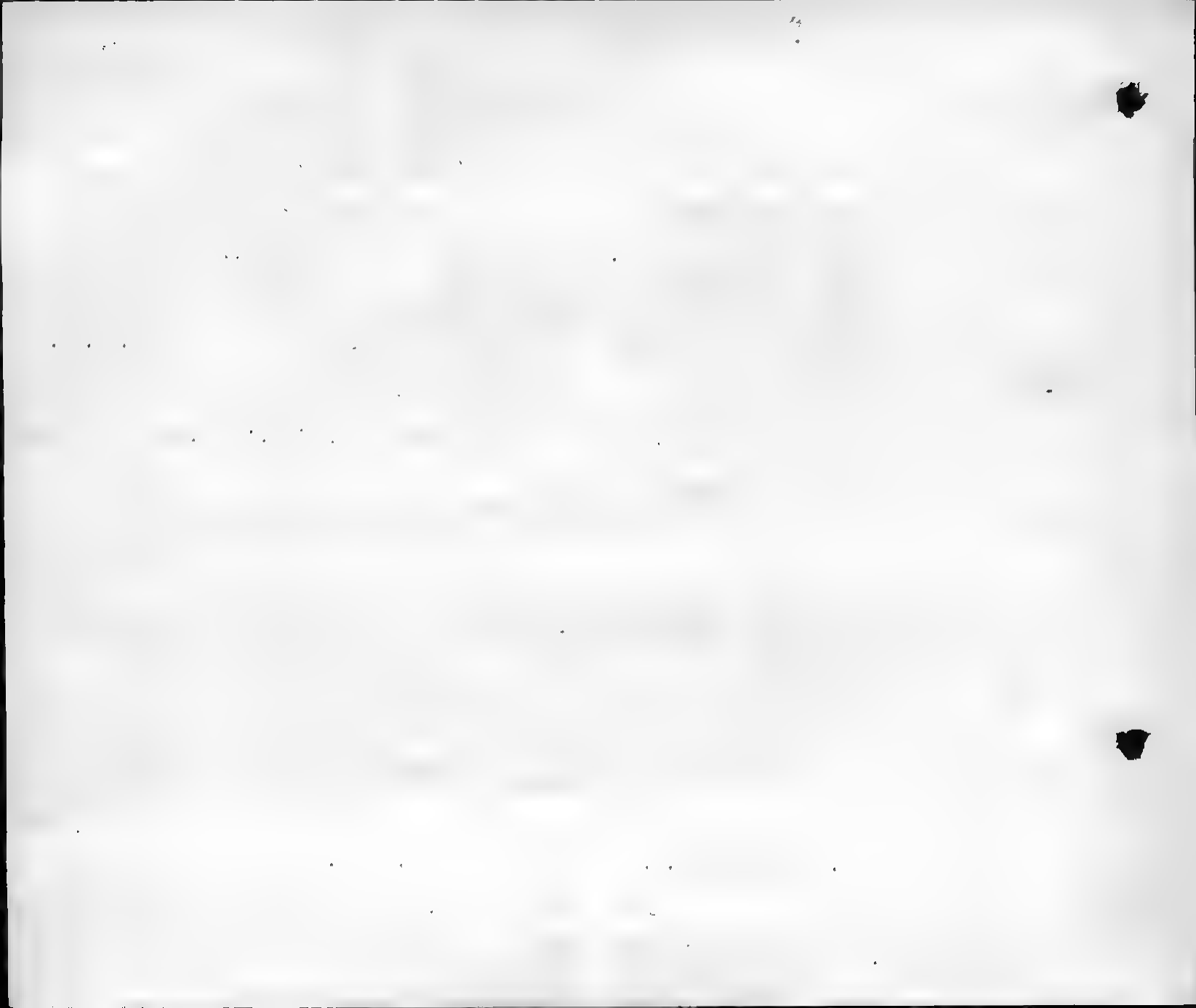
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8814

08781

| | | | | | | | |
|---|---------------------------------|--|--|---|--|---|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived - If institut on: Residence before adm ssion) a. STATE Maryland b. COUNTY | | | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland | | | | c LENGTH OF STAY IN 1b 21 Days | | | |
| d NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Veterans Administration Hospital | | | | e STREET ADDRESS 2414 East Biddle Street | | | |
| f IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3 AGE OF DECEASED (Type or print) JAMES | | First A. | | Middle BENTON | | Last | |
| 4 DATE OF DEATH August | | Month | | Day 26 | | Year 1960 | |
| 5 SEX Male | 6 COLOR OR RACE Negro | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 AGE (in years last birthday) 40 yrs | | IF UNDER 1 YEAR Months Days Hours Min | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Laundry Extractor | | | | 10b KIND OF BUSINESS OR INDUSTRY Laundry | | 11 BIRTHPLACE (State or foreign country) North Carolina | |
| 12 CITIZEN OF WHAT COUNTRY? U. S. A. | | | | | | | |
| 13 FATHER'S NAME Augusta Benton | | | | 14 MOTHER'S MAIDEN NAME Hixie Pickett | | | |
| 15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16 SOCIAL SECURITY NO. WW II | | 17 INFORMANT Clinical Records, VAH, Balto. 18, Md. | | Address FORT HOWARD DIV. | |
| 18. CAUSE OF DEATH [Enter on only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: 442X DUE TO BRONCHOPNEUMONIA DUE TO HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary infarcts, recent and old. | | | | | | | |
| 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Baltimore | |
| 20f (City or town) Baltimore | | | | (County) Maryland | | (State) | |
| 21 I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 5 1960 to August 26 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 26 1960 , and that death occurred at 7:32 AM , from the causes and on the date stated above. | | | | | | | |
| 22a SIGNATURE Fredrick S. Donaldson M.D. | | | | 22b DATE SIGNED 8/26/60 | | 22c PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D. | |
| 22d ADDRESS VAH, BALTO. 18 MD. FORT HOWARD DIVISION | | | | | | | |
| 23a BURIAL, CREMATION OR REMOVAL (Specify) Burial | | 23b DATE THEREOF 8/30/60 | | 23c NAME OF CEMETERY OR CREMATORY Baltimore National Cem. | | 23d LOCATION (City, town, or county) (State) Baltimore Maryland | |
| 24 FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips | | | | 25a REC'D BY REGISTRAR SEP 1 '60 | | 25b REGISTRAR'S SIGNATURE Arthur S. House | |

MEDICAL CERTIFICATION



CERTIFICATE OF DEATH

Reg. Dist. No. 32

8815

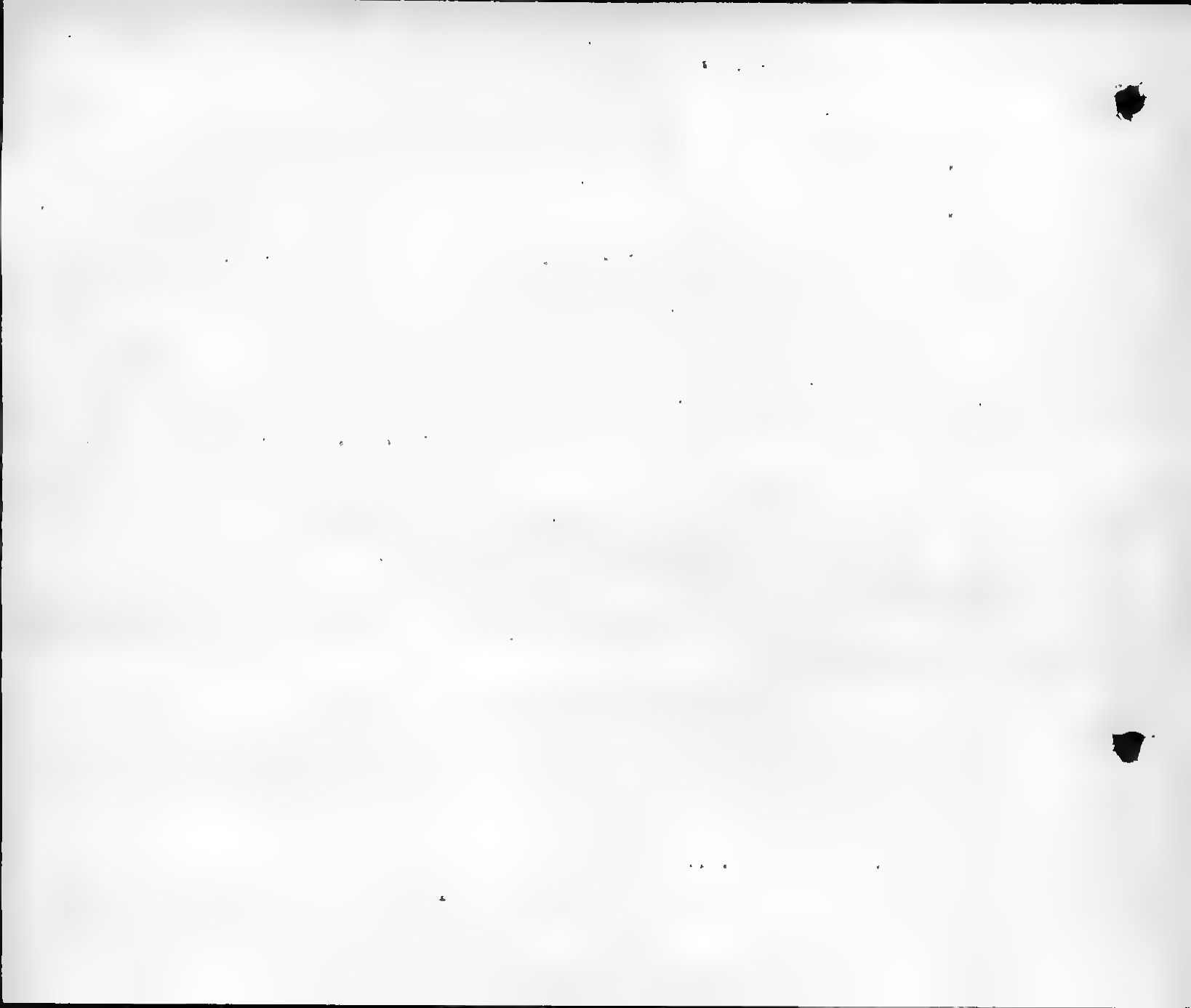
Page 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived if institut on Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland | | | | c. LENGTH OF STAY IN 1b 16 day | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital | | | | e. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Silver Spring | | | |
| f. STREET ADDRESS 8628 Piney Branch Road | | | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) JOSEPH First CEPHUS Middle BLANTON Last | | | | 4. DATE OF DEATH Month August Day 19 Year 1960 | | | |
| 5. SEX M | | 6. COLOR OR RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 5.2.1880. | |
| 9. AGE (In years last birthday) 80 yrs. | | 10. IF UNDER 1 YEAR Months 80 Days 80 Hours 80 Min | | 11. IF UNDER 24 HRS | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) North Carolina | | 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME HANSEL BLANTON | |
| 14. MOTHER'S MAIDEN NAME ELIZABETH SHEPPHARD | | 15. WAS DECEASED EVER IN U S ARMED FORCES? (If yes, give war or dates of service) unknown | | 16. SOCIAL SECURITY NO None | | INFORMANT Address Hospital Records, Mt. Wilson State Hospital | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extremely far advanced bilateral ca- 2.5 ntary pulmonary tuberculosis with destroyed left lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (a) destroyed left lung DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c). 1. Arteriosclerotic heart disease 2. Arteriosclerosis generalised | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 8.4 1960 to 8.19 1960 , that I last saw the deceased alive on 8.19 1960 , and that death occurred at 11:20 AM , from the causes and on the date stated above ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE William Newcomer M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) W. Newcomer, M.D., Superintendent | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) 8-19-60 | | | | 22b. DATE THEREOF | | | |
| 22c. NAME OF CEMETERY OR CREMATORY Protestant Cemetery | | | | 22d. LOCATION (City, town, or county) (State) Montgomery, N.C. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newcomer, Baltimore, Md. | | | | 24. REC'D BY REGISTRAR DATE SEP 19 '60 | | | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | | | | | |



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8816

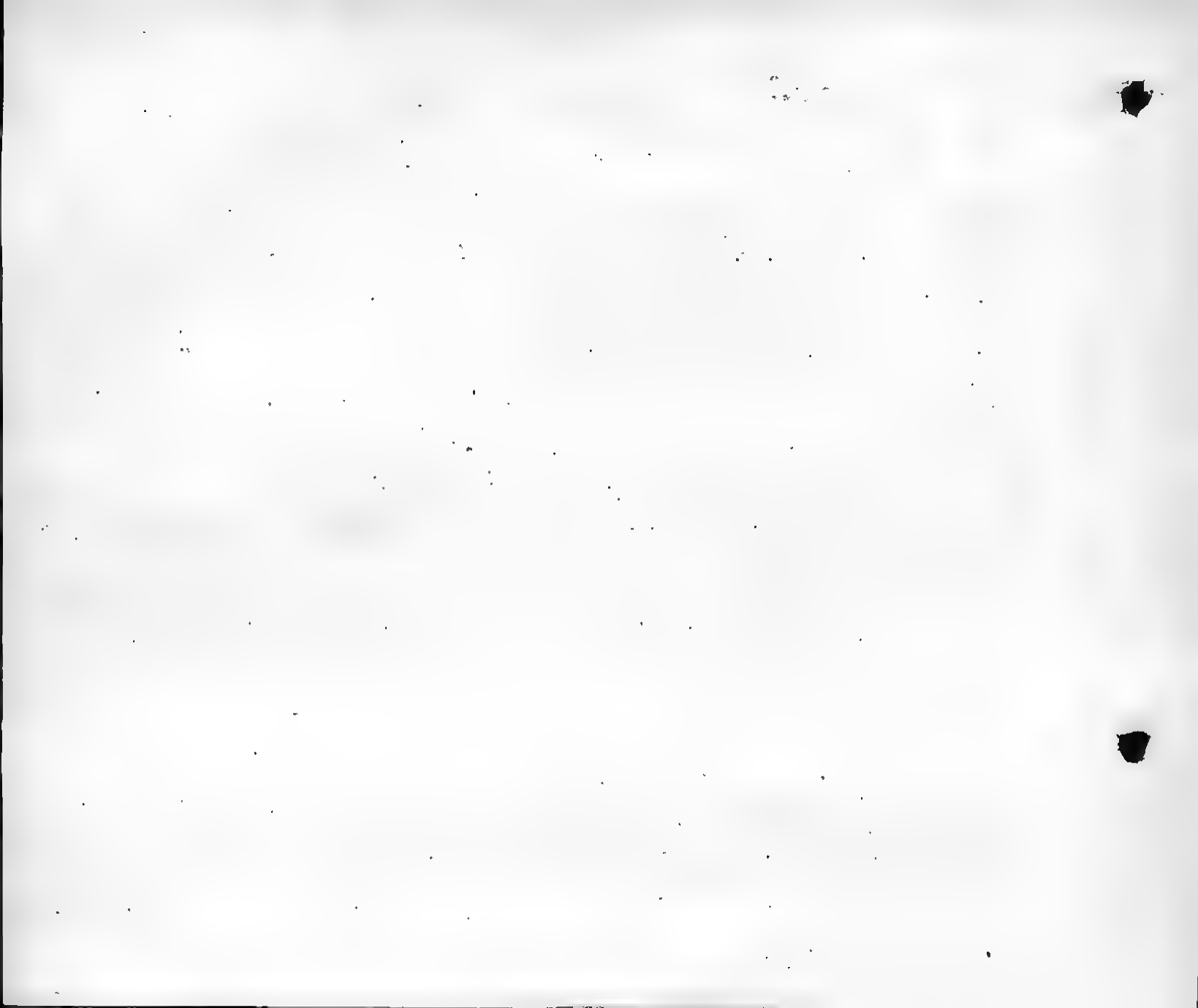
CERTIFICATE OF DEATH

Reg. Dist. No. 08782

| | | | | | |
|---|----------------------------------|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN TB Baltimore | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home | | e. STREET ADDRESS 5303 Wesley Avenue | | f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) MARY HOLLINGSWORTH BOWERMAN | | 4. DATE OF DEATH Month August Day 14 Year 1960 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 25, 1865 | 9. AGE (in years last birthday) 94 yrs. | 10. FUNERAL YEAR Months 14 Days 14 Hours 14 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home | | 10b. KIND OF BUSINESS OR INDUSTRY Baltimore Maryland | | 11. BIRTHPLACE (State or foreign country) USA | |
| 13. FATHER'S NAME William H. Gibson | | 14. MOTHER'S MAIDEN NAME Caroline Taylor | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | INFORMANT Mrs. Walter N. Linthicum | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anteroselectic cardiovascular diseases 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 5 yrs + | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that I attended the deceased from March 1960 to 8-14-60 , 19 60 , that I last saw the deceased alive on 8-14-60 , 19 60 , and that death occurred at 4:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Balt. 2, Md DATE SIGNED 8-15-60 | | | | | |
| ACTUAL SIGNATURE John A. Nesbitt, Jr. | | M.D. | | | |
| PHYSICIAN'S NAME (Type) John A. Nesbitt, Jr., M.D. | | 1118 St. Paul Street | | Balt. 2, Md | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/16/1960 | | 22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery | |
| 22d. LOCATION (City, town, or county) Pikesville | | (State) Maryland | | 24a. REC'D BY REGISTRAR DATE Aug 17 '60 | |
| 24b. REGISTRAR'S SIGNATURE Ellsworth Armacost | | 24c. REGISTRAR'S SIGNATURE Ellsworth Armacost | | | |



| | | | |
|--|--|---|--|
| 1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Tunnsville</u> | | c. LENGTH OF STAY IN 1b <u>10 years</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Tunnsville</u> | |
| | | d. STREET ADDRESS <u>1 Stoney Batter Rd.</u> | |
| | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH MARTIN BOWERS</u> SA | | | |
| 4 DATE OF DEATH Month Day Year <u>Aug 11 1960</u> | | | |
| 5 SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>JUNE 10 1890</u> | |
| 9 AGE (In years lost birthday) <u>70</u> yrs | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USULA OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter (Retired)</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>B+O Railroad</u> | |
| 11 BIRTHPLACE (State or foreign country) <u>Va.</u> | | 12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13 FATHER'S NAME <u>BENJAMINE F. BOWERS</u> | | 14. MOTHER'S MAIDEN NAME <u>SARAH CATHERINE KIRBY</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16 SOCIAL SECURITY NO <u>705-05-6011</u> | |
| INFORMANT Address <u>Mrs. Edyth B. Patterson Bowers</u> | | <u>Rd. 11, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> | | | |
| DUE TO <u>Arteriosclerotic Cardiovascular Dis 5 yrs.</u> | | | |
| DUE TO | | | |
| DUE TO | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PULMONARY TUBERCULOSIS (1953-1954)</u> | | | |
| 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month Day Year Hour o.m. p.m. <u>8/10 1960 7/37</u> | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21 I certify that I attended the deceased from <u>7/37</u> , 19 <u>53</u> , to <u>8/11</u> , 19 <u>60</u> that I last saw the deceased alive on <u>8/10</u> , 19 <u>60</u> and that death occurred at <u>5 P.</u> M, from the causes and on the date stated above. | | | |
| ADDRESS (Street, city or town, state) <u>FORK MD.</u> DATE SIGNED <u>8/11/60</u> | | | |
| ACTUAL SIGNATURE <u>CLIFFORD F. HUDSON</u> | | | |
| PHYSICIAN'S NAME (Type) <u>CLIFFORD F. HUDSON</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | |
| 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| 23 FUNERAL DIRECTOR'S SIGNATURE <u>Charles C. Hunt</u> | | ADDRESS <u>Harrodsville</u> | |
| 24a. RECEIVED BY REGISTRAR <u>Aug 15 60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hunt</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

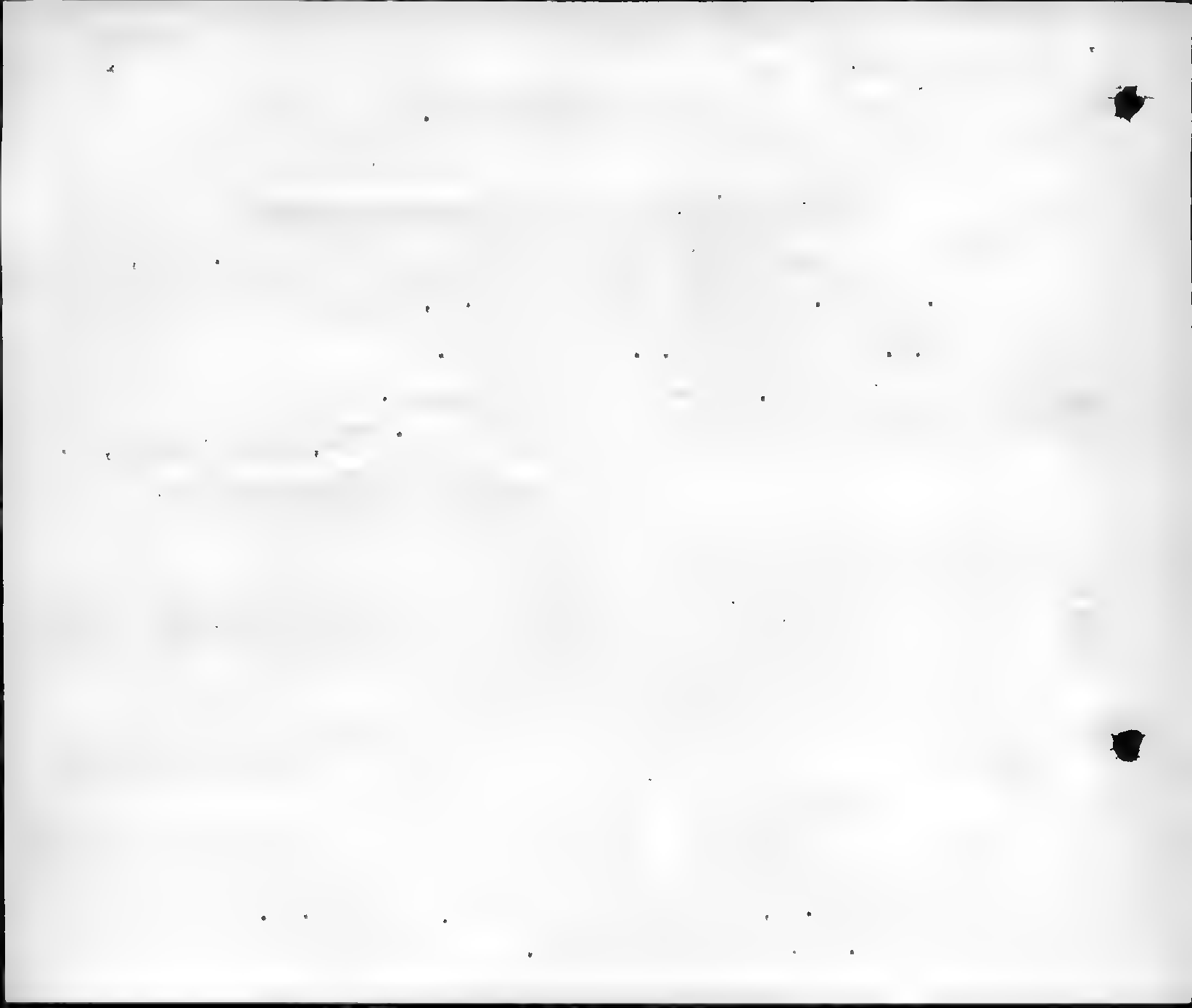
8818

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08784

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Md. b. COUNTY L. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | | c. LENGTH OF STAY IN 1b 5-2 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Summit Nurs. Home 98 Smithwood Ave | | | | d. STREET ADDRESS 634 North Bend Rd | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Mary (Mollie) Bramble | | | | 4. DATE OF DEATH Month Day Year Aug. 10, 1960 | | | |
| 5. SEX F. | | 6. COLOR OR RACE W. | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Sept. 12, 1876 | |
| 9. AGE (in years last birthday) 83 | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W. | | 10b. KIND OF BUSINESS OR INDUSTRY O.H. | | 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME George W. Watson | | | | 14. MOTHER'S MAIDEN NAME Mary E. Van Newkirk | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT Address Mrs Helen R. Stevens 634 North Bend Rd, Catonsville 28, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 450.5 DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Blindness Chronic Brain Syndrome INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Feb 15 1960 to 8/10/60 , that (I) was lost saw the deceased alive on 8/10/60 and that death occurred 6:00 P.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE W.E. McGreth | | | | 22b. ADDRESS 1303 Frederick Rd (28) | | | |
| 22c. PHYSICIAN'S NAME (Type) W.E. McGreth | | | | 22d. ADDRESS 1303 Frederick Rd (28) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Aug. 13, 1960 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemty. | | 23d. LOCATION (City, town, or county) (State) Balto. Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Witzke Fun. Dir. 4101 Edmondson Ave. | | | | 25a. REC'D BY REGISTRAR DATE AUG 16 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kline | |

MEDICAL CERTIFICATION

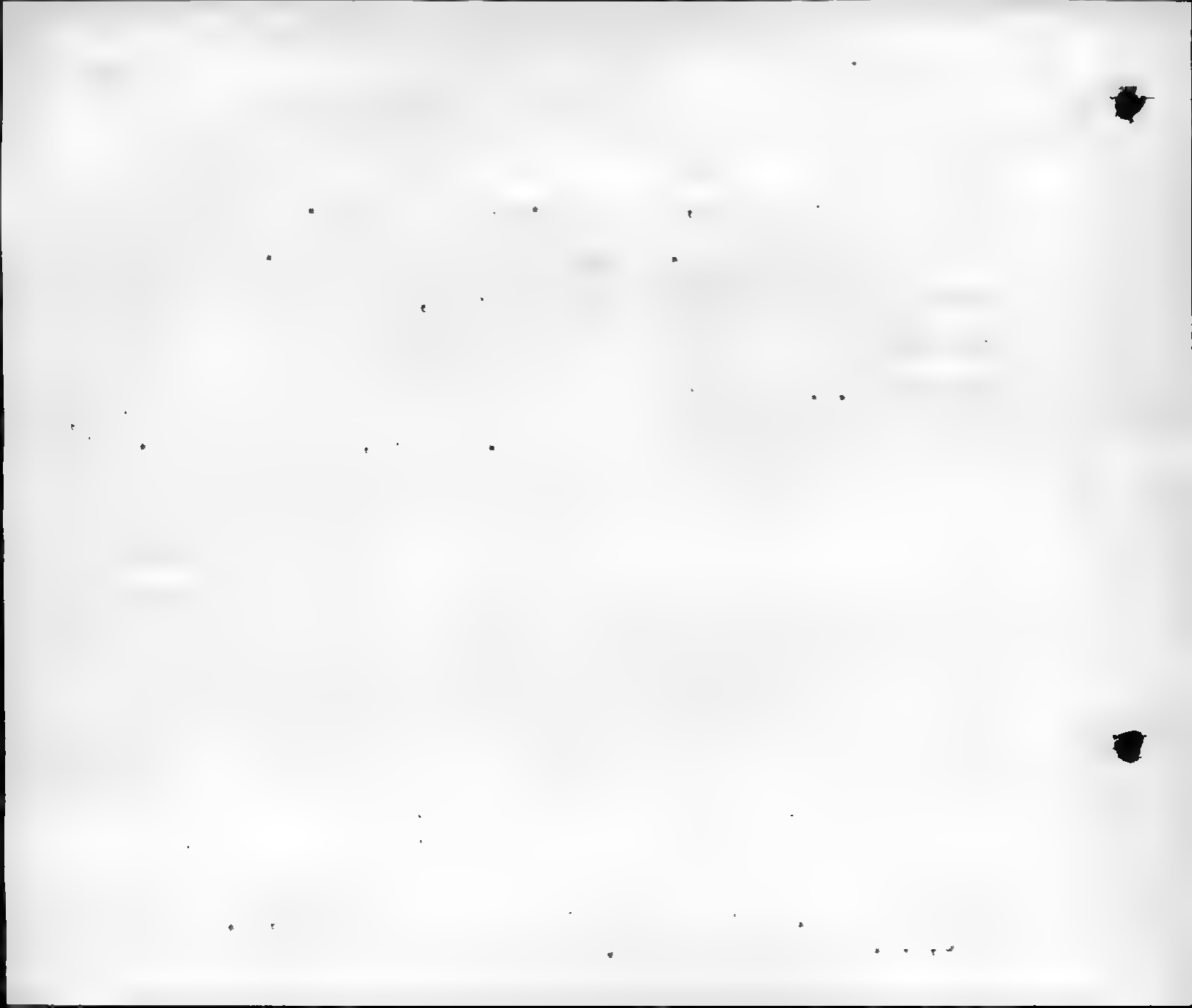


Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
8819
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08785

| | | | |
|---|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home, Rolling Rd. | | e. STREET ADDRESS 229 Clovelly Rd. | |
| 3. NAME OF DECEASED (Type or print) First Eva Middle H. Brewer Last | | 4. DATE OF DEATH Aug. 8/60 Month Aug. Day 8 Year 19 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 19, 1890 |
| 9. AGE (in years, last birthday) 70 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleswoman | | 10b. KIND OF BUSINESS OR INDUSTRY Virginia | |
| 11. BIRTHPLACE (State or foreign country) USA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME W.T. Hutchinson | | 14. MOTHER'S MAIDEN NAME Cleo Hancock | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO | |
| 17. INFORMANT John S. Hawkins, 229 Clovelly Rd. Ellicott City, Md. | | Address City, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) arteriosclerotic cerebro-cardiovascular disease DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH 3 yrs + | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1956 19 8-8-60 , that (I) (we) last saw the deceased alive on 8-8-60 19 10:35 AM, and that death occurred at 10:35 AM, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE John A. Nesbitt, Jr. | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) JOHN A. NESBITT, JR. | | 22d. ADDRESS 1118 At Paul St Baltimore 2, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE THEREOF Aug. 8/60 | |
| 23c. NAME OF CEMETERY OR CREMATORY Evergreen | | 23d. LOCATION (City, town, or county) (State) Roanoke, Va. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Witzke, F.D. 4101 Edmondson Ave. | | 25a. REC'D BY REG STRAR AUG 9 '60 DATE | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Kneel | | | |



FOR STATE
HEALTH DEPT.

(M)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

8820

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08786

1. PLACE OF DEATH
a. COUNTY **Baltimore** MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Sparks**
c. LENGTH OF STAY IN 1b **LIFE**
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Boad of Cold Bottom Road**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE **Maryland** b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Lutherville**
d. STREET ADDRESS **1422 Railroad Avenue**

3. NAME OF DECEASED (Type or print) **ESTELLE J. BROWN**
4. DATE OF DEATH **August 23 1960**
5. SEX **Female** 6. COLOR OR RACE **Colored** 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH **June 30, 1938** 9. AGE (In years If UNDER 1 YEAR If UNDER 24 HRS. last birthday) **22** yrs. **22** Months **23** Days **22** Hours **22** Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Nurse** 10b. KIND OF BUSINESS OR INDUSTRY **Hospital** 11. BIRTHPLACE (State or foreign country) **U.S.A.** 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME **Mr. N. Brown** 14. MOTHER'S MAIDEN NAME **Evelyn Miller**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No** 16. SOCIAL SECURITY NO. **Unknown** 17. INFORMANT **Mr. N. Brown** Address **1422 Railroad Ave**

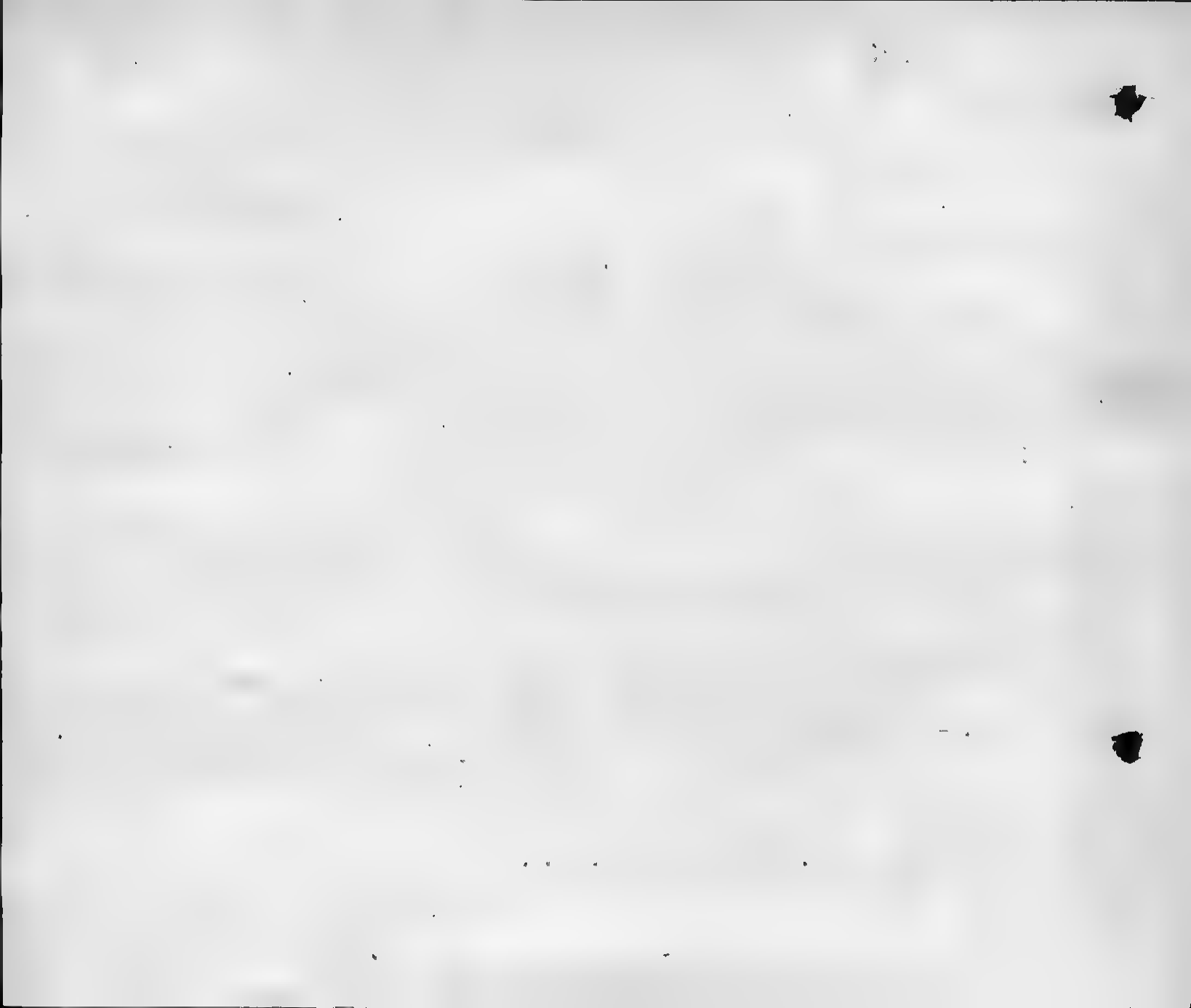
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Gunshot wound of head**
DUE TO (b) **981X**
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) **Apparently shot during case of homicide-suicide**
20c. TIME OF INJURY Month, Day, Year **Oct. 5-6 8/22 1960** 20d. INJURY OCCURRED While ☐ Not While ☒ at work ☐ at work ☒ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **Auto** 20f. (City or town) **Baltimore** (County) **Md.**

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐
CHIEF MEDICAL EXAMINER **W. Bradley King, Jr., M.D.** ASSISTANT MEDICAL EXAMINER ☒ DATE SIGNED **8/24/60**
DEPUTY MEDICAL EXAMINER ☐

22a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 22b. DATE THEREOF **8/26/60** 22c. NAME OF CEMETERY OR CREMATORY **Pleasant Rest** 22d. LOCATION (City, town, or country) **Towson** (State)
23. FUNERAL DIRECTOR **W. Bradley King, Jr., M.D.** ADDRESS **1741 N. Calvert St. Balt. Md.** 24a. REC'D BY REGISTRAR **AUG 26 1960** 24b. REGISTRAR'S SIGNATURE **Charles S. Kline**

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

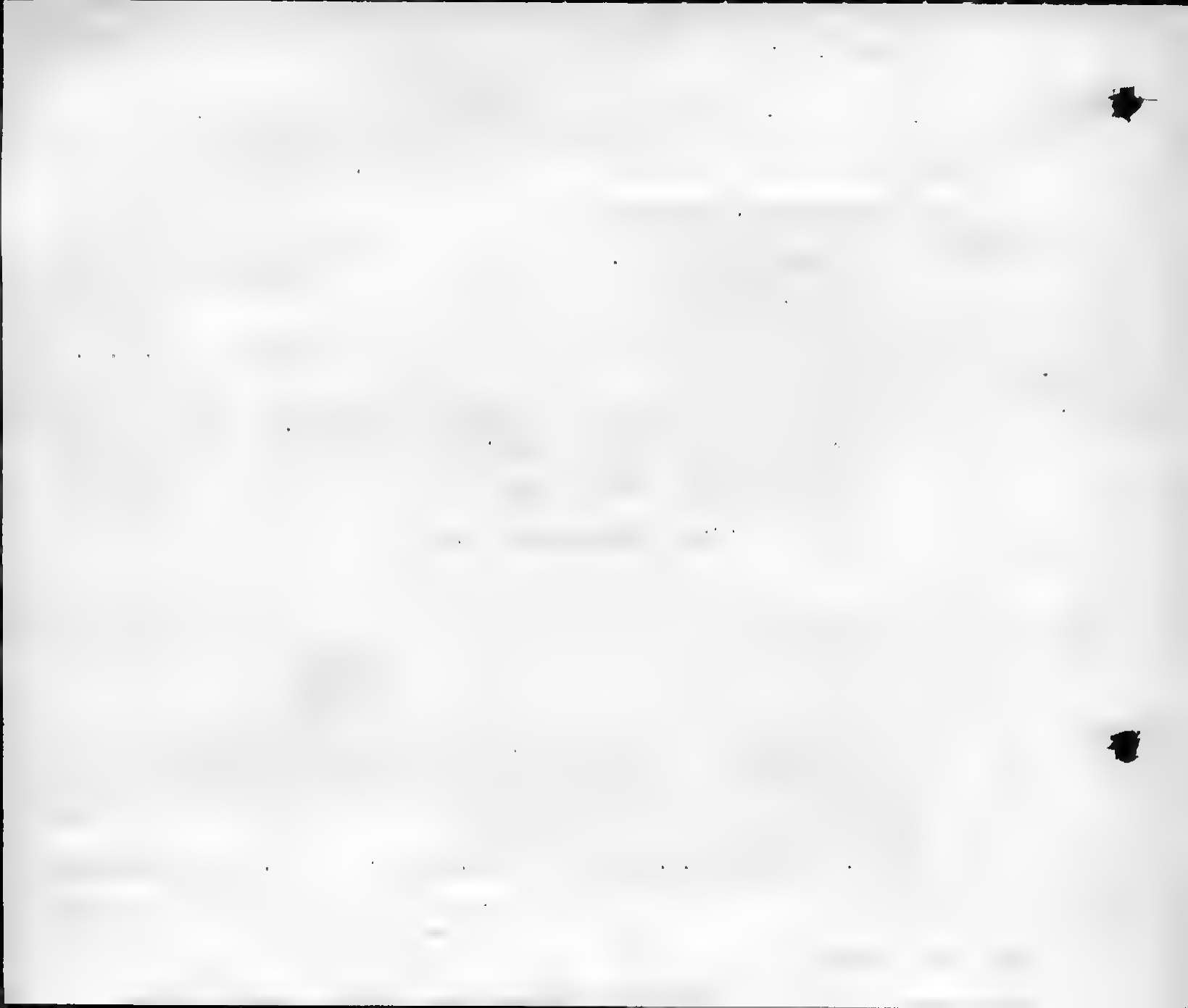
VR A15 (4)
15M 9/59

8821

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09920

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Dorchester STATE Maryland | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. LENGTH OF STAY IN 1b 33 Days | | c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Hurlock (Rural) | | | |
| d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | d. STREET ADDRESS -- | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First HERMAN Middle L. Last BROWN | | | | 4. DATE OF DEATH Month August Day 31 Year 1960 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Colored | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH November 6, 1922 | |
| 9. AGE (in years last birthday) 37 | | 10. IF UNDER 1 YEAR Months 37 Days 0 Hours 0 Min 0 | | 11. BIRTHPLACE (State or foreign country) Weldon, North Carolina | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Farming | | 11. BIRTHPLACE (State or foreign country) Weldon, North Carolina | |
| 13. FATHER'S NAME Frank Brown | | | | 14. MOTHER'S MAIDEN NAME Reola Ridley | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II | | | | 16. SOCIAL SECURITY NO. 215-26-4616 | | 17. INFORMANT 3900 Loch Raven BLVBaltimore 18, Maryland Clin.Rec.Vet.AHospital,Fort Howard Division | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA 5X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) MULTIPLE PULMONARY EMBOLISMS DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 Hour | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 Hour | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS - | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month July Day 29 Year 1960 Hour 11:30 a.m. 60 p.m. | | 20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VAH, BALTIMORE 18, MD., FORT HOWARD DIVISION | | 20f. (City or town) (County) (State) | |
| 21. I certify that (a) (this hospital) attended the deceased from July 29, 1960 to August 31, 1960 , that (b) (we) last saw the deceased alive on Aug. 31, 1960 , and that death occurred at 11:30 p.m. from the causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE Frederick S. Donaldson | | | | 22b. DATE SIGNED 9/2/60 | | 22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D. | |
| 22d. ADDRESS VAH, BALTIMORE 18, MD., FORT HOWARD DIVISION | | | | 22e. ADDRESS VAH, BALTIMORE 18, MD., FORT HOWARD DIVISION | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 9-5-60 | | 23c. NAME OF CEMETERY OR CREMATORY East New Market Cemetery | | 23d. LOCATION (City, town or county) (State) East New Market, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE St. Clair Funeral Home | | | | ADDRESS Cambridge, Maryland | | 25a. REC'D BY REGISTRAR DATE SEP 14 '60 | |
| 25b. REGISTRAR'S SIGNATURE SEP 14 '60 | | | | 25c. REGISTRAR'S SIGNATURE SEP 14 '60 | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

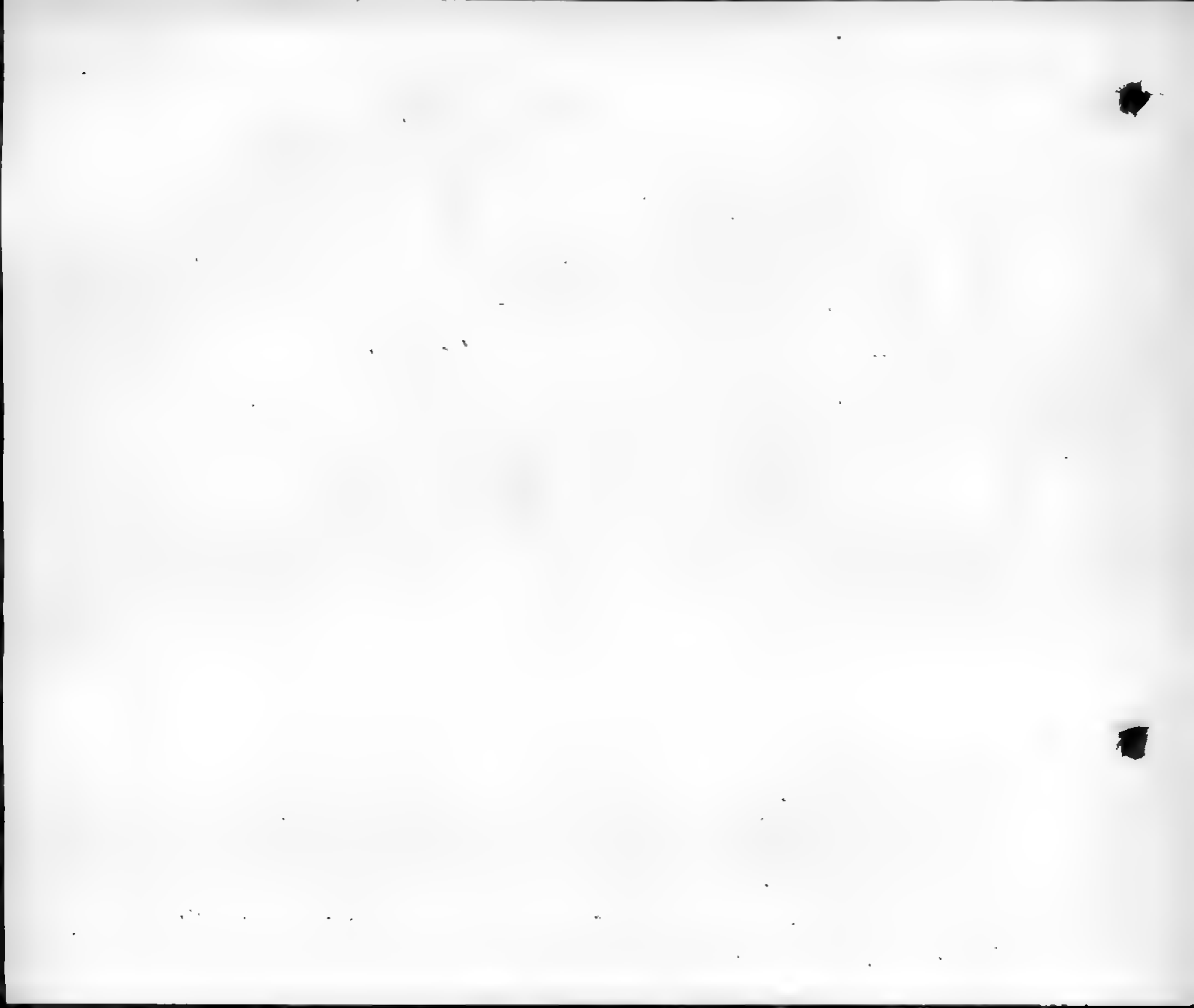
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

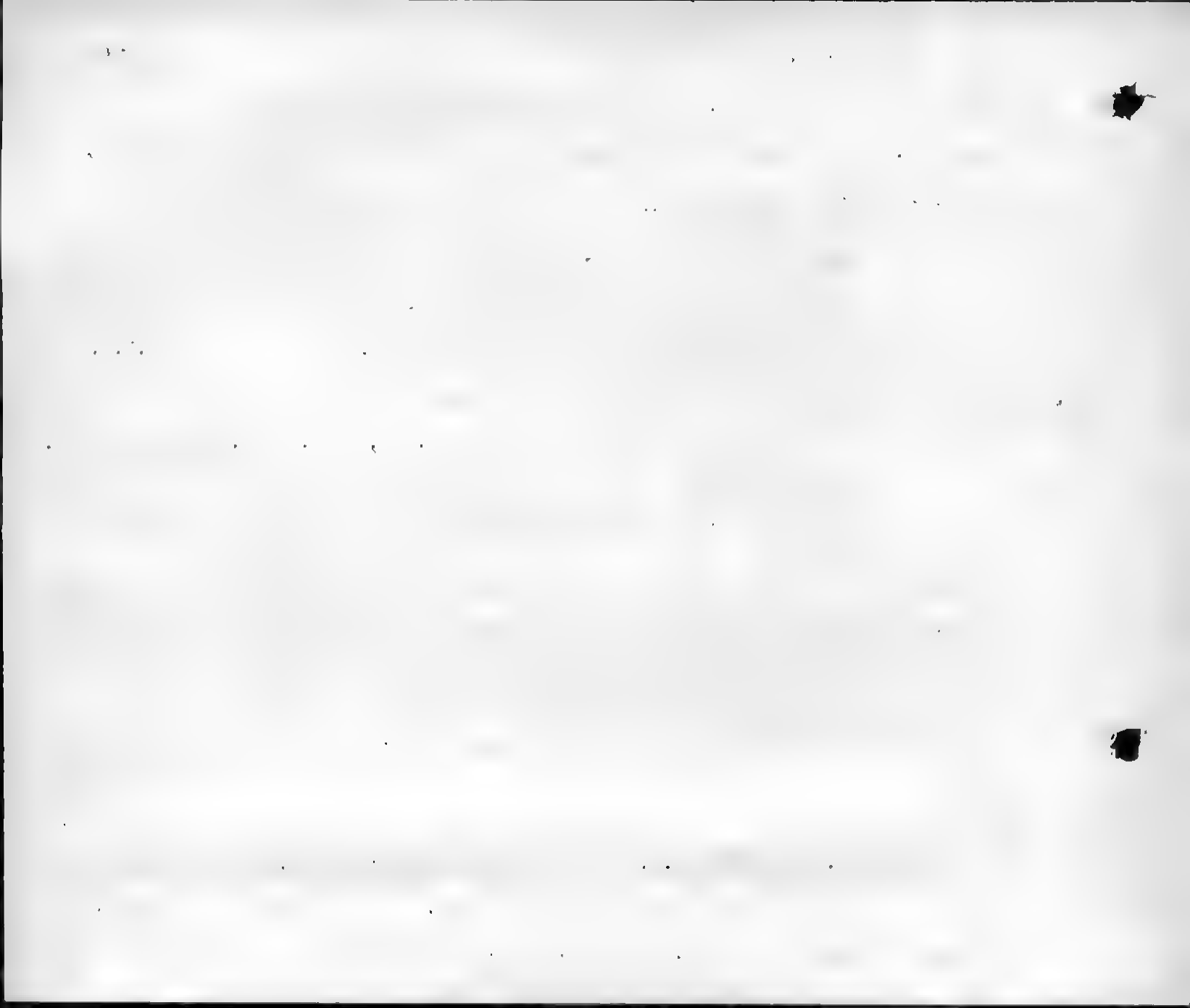
8822

CERTIFICATE OF DEATH

Reg. Dist. No. 08787

| | | | |
|--|---------------------------------|---|---|
| 1 PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE <i>Md.</i> b. COUNTY <i>Baltimore</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <i>Parkville</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8033 Highpoint Road</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First <i>Katherine</i> Middle <i>Edna</i> Last <i>Brown</i> | | 4. DATE OF DEATH Month <i>August</i> Day <i>4</i> Year <i>19 60</i> | |
| 5 SEX <i>female</i> | 6 COLOR OR RACE <i>white</i> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <i>7-14-1903</i> |
| 9. AGE (In years last birthday) <i>57</i> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i> | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | 11 BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 13. FATHER'S NAME <i>George P. Streb</i> | |
| 14. MOTHER'S MAIDEN NAME <i>Johanna Ackerman</i> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>same</i> | |
| 16. SOCIAL SECURITY NO | | 17. INFORMANT <i>Fred Brown</i> Address <i>same</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metastatic carcinoma</i> 199.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>June</i> , 19 <i>60</i> , to <i>Aug 4</i> , 19 <i>60</i> that I last saw the deceased alive on <i>July 20</i> , 19 <i>60</i> , and that death occurred at <i>4:45</i> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE <i>Franklin E. Leslie</i> M.D. | | 29 29 2. Charles Balbo I.F. had | |
| PHYSICIAN'S NAME (Type) <i>Franklin E. Leslie</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i> | 22b. DATE/TIME OF <i>8/5/60</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Gardens of Faith</i> | 22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> | | 24a. REC'D BY REGISTRAR DATE <i>AUG 5 '60</i> | |
| ADDRESS <i>5305 Hartford Rd.</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> | |





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8824

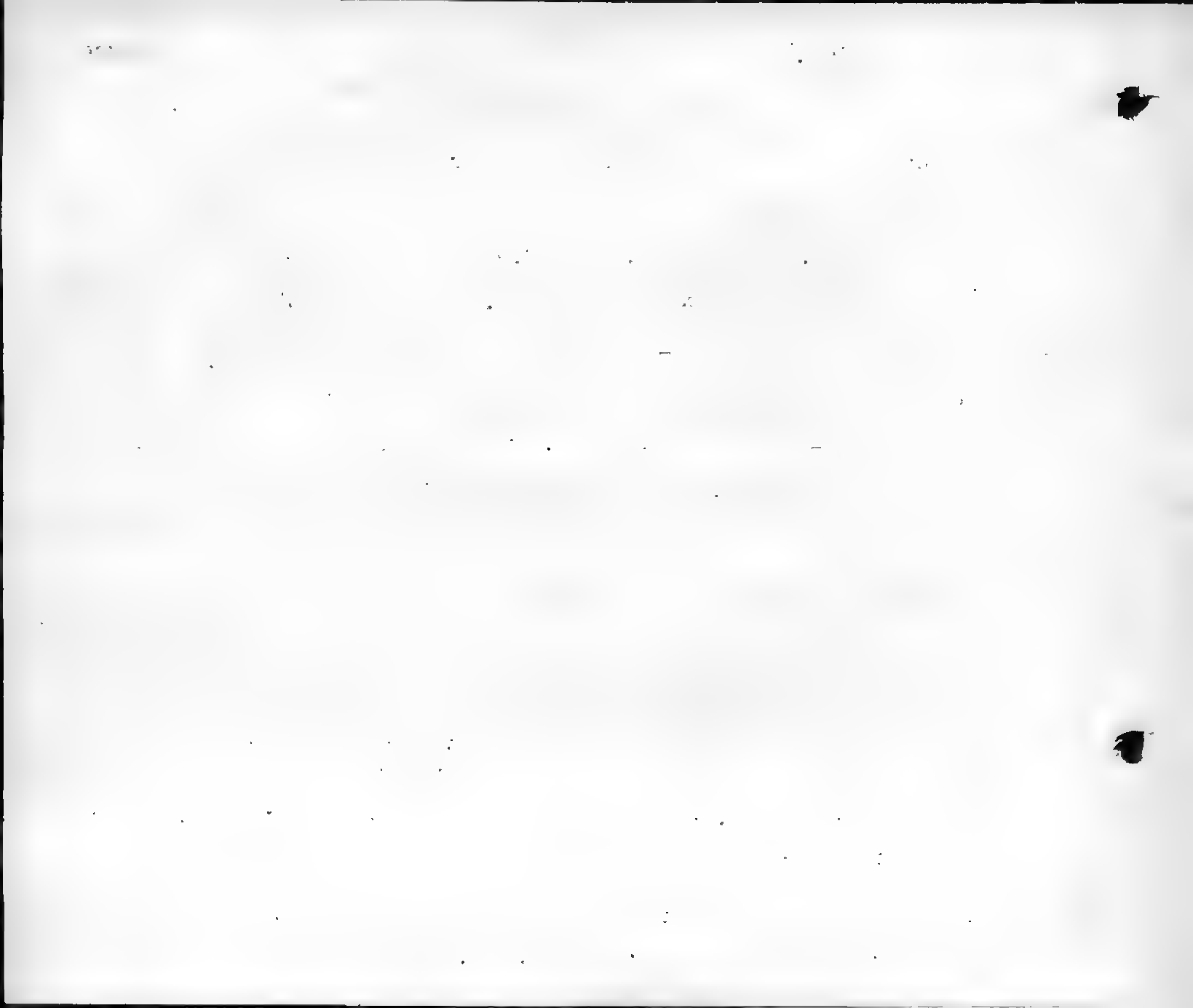
CERTIFICATE OF DEATH

Reg. No. 08789

| | | | |
|---|---|--|---|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | c. LENGTH OF STAY IN lb 5 years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 22 Normal Terrace | | e. STREET ADDRESS 22 Normal Terrace | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Mrs. Cecelia M. Bryant | | 4 DATE OF DEATH Month Day Year August 26 1960 | |
| 5 SEX Female | 6 COLOR OR RACE White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 2, 1865 |
| 9 AGE (in years last birthday) 94 yrs | | 10. FUND 1 YEAR IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home | | 10b. KIND OF BUSINESS OR INDUSTRY - | |
| 11 BIRTHPLACE (State or foreign country) Maryland | | 12 CITIZEN OF WHAT COUNTRY? USA | |
| 13 FATHER'S NAME John Shauck | | 14 MOTHER'S MAIDEN NAME Louisa Hubbard | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. - | |
| INFORMANT A. Thomas Bryant | | Address 22 Normal Terrace, Towson | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 422 DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 12 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1957 to July 26 , 1960, that I last saw the deceased alive on July 29, 1960 , and that death occurred at 2:20 P. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE William A. Piller M.D. | | ADDRESS (Street, city or town, state) DATE SIGNED Towson, Md. 8/29/60 | |
| PHYSICIAN'S NAME (Type) William A. Piller | | | |
| 22a BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b DATE THEREOF Aug 30, 1960 | 22c NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery | 22d LOCATION (City, town, or county) (State) Pikesville, Maryland |
| 23 FUNERAL DIRECTOR'S SIGNATURE Burgess Funeral Home | | ADDRESS 3631 Falls Road Balto, Md. | |
| 24a REC'D BY REGISTRAR DATE AUG 30 '60 | | 24b REGISTRAR'S SIGNATURE Arthur S. Kraus | |

By: *[Signature]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

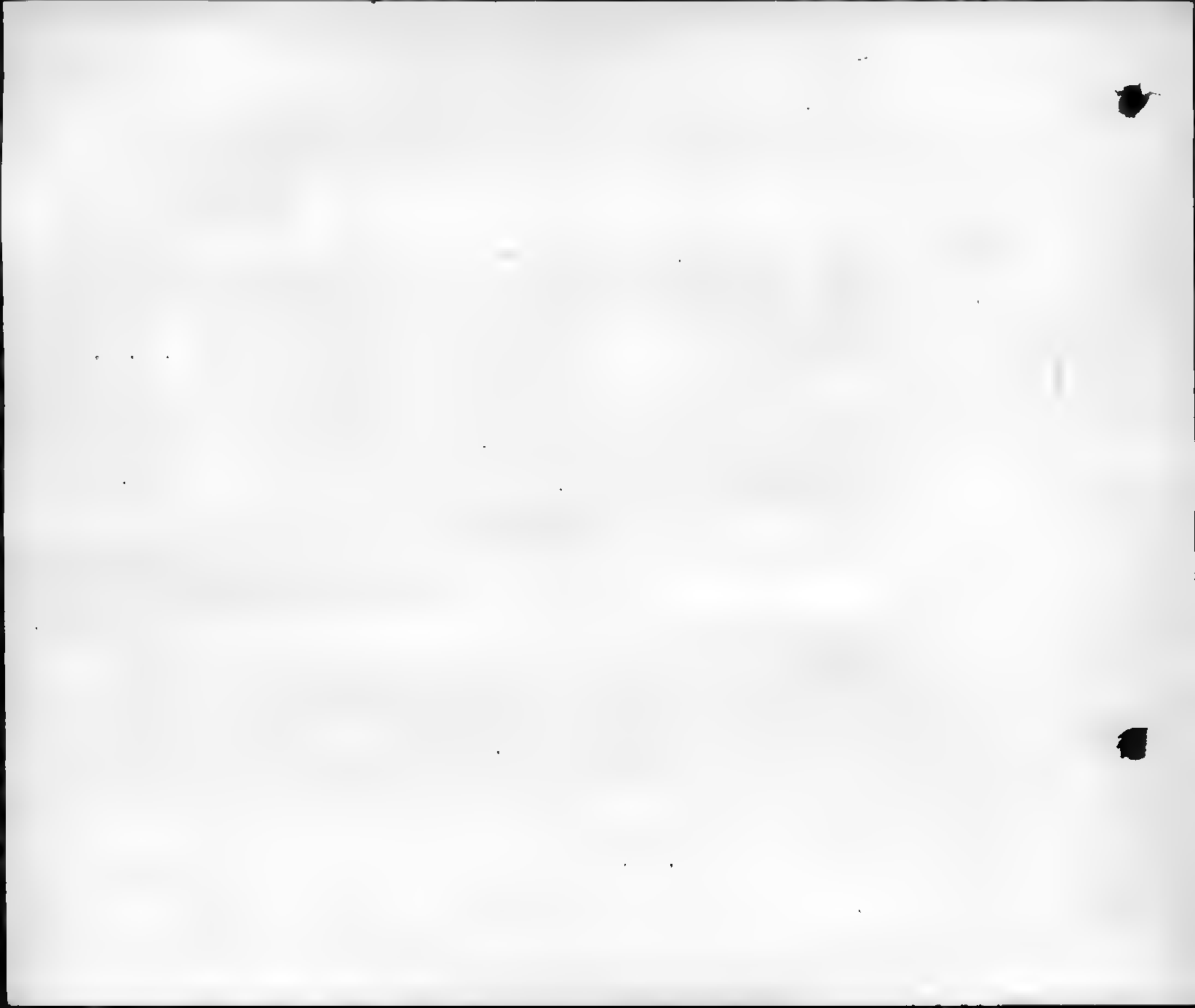
8825

UNITED STATES DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08790

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 24yrl0mth22dys d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | | | 2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1114 Hewitt Way e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3 NAME OF DECEASED (Type or print) First Lavinia Middle BUNCE Last Bunce | | | | 4 DATE OF DEATH Month 8 Day 12 Year 1960 | | | |
| 5. SEX female | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH March 19, 1903 | |
| 9. AGE (In years last birthday) 57 yrs | | 10. IF UNDER 1 YEAR Months 57 Days 12 Hours 19 Min 00 | | 11. IF UNDER 24 HRS Months 57 Days 12 Hours 19 Min 00 | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY New York | | | |
| 11. BIRTHPLACE (State or foreign country) New York | | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO Unknown | | | |
| 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | | | Address SPRING GROVE STATE HOSPITAL | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO renal failure Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. nephritis (b) gums infected (c) 1 week | | | | | | INTERVAL BETWEEN ONSET AND DEATH 11 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) gums infected | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 10 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) SPRING GROVE STATE HOSPITAL | |
| 20f. (City or town) Catonsville | | | | 20g. (County) Maryland | | 20h. (State) Maryland | |
| 21. I certify that (I) (this hospital) attended the deceased from Aug. 6, 1960 to Aug. 12, 1960 that (I) (we) last saw the deceased alive on Aug. 12, 1960 , and that death occurred at 10:30 PM , from the causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE P. K. YIP | | | | 22b. DATE SIGNED Aug 12 1960 | | | |
| 22c. PHYSICIAN'S NAME (Type) P. K. YIP, M.D. | | | | 22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Buried | | | | 23b. DATE THEREOF Aug-15-60 | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Baltimore Cem | | | | 23d. LOCATION (City, town or county) (State) Balto. Md | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE John C. Meller | | | | 25. REC'D BY REGISTRAR AUG 17 '60 | | | |
| 25a. ADDRESS 2431 E. Olney St | | | | 25b. REGISTRAR'S SIGNATURE Arthur L. Thomas | | | |

10-10850-1-59



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8826

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08791

| | | | |
|---|---------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE OR MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTO | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Catonsville | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital | | e. STREET ADDRESS 1273 RIVERSIDE AVE | |
| 3. NAME OF DECEASED (Type or print) Matilda G. Burnett | | 4. DATE OF DEATH Month 8 Day 7 Year 1960 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH October 2 1877 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home duties | | 11. BIRTHPLACE (State or foreign country) Germany | |
| 13. FATHER'S NAME Mr. Unknown | | 14. MOTHER'S MAIDEN NAME Mr. Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. Spring Grove St. Hosp. Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 904 Acute Cardiac Failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular heart disease DUE TO (c) fracture left femur Accident | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FATAL DISEASE CONDITION GIVEN IN PART I (a) no history of injury or mechanism of fracture | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year 4 to 7 P.M. 8.6.60 | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> on work <input type="checkbox"/> off work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Spring Grove St. Hosp. | | 20f. (City or town) Catonsville (County) Balto. (State) Md | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE Geo. W. Kieffer | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) GEO. W. KIEFFER M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) B | | 22b. DATE THEREOF 8-11-60 | |
| 22c. NAME OF CEMETERY OR CREMATORY Holy Cross | | 22d. LOCATION (City, town, or county) Balto. (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. E. Taylor | | ADDRESS 130 E. Towson Ave. | |
| 24a. REC'D BY REGISTRAR Aug 10 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur E. House | |

MEDICAL CERTIFICATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8790 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08792

| | | | |
|---|-------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22) c. LENGTH OF STAY IN lb 20 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 135 Ventnor Terrace | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22) d. STREET ADDRESS 135 Ventnor Terrace e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First PARTICK Middle EDWARD Last BUTLER | | 4. DATE OF DEATH Month August Day 10th Year 19 60 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 18, 1893 |
| 9. AGE (In years last birthday) 66 yrs. | | 10. UNDER 1 YEAR IF UNDER 24 HRS Months 6 Days 10 Hours 10 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R.R. Mail Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY Postal Service | |
| 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Butler | | 14. MOTHER'S MAIDEN NAME Mary Cavanaugh | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give year or dates of service) WWI | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Ann M. Butler | | Address same as #2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A-S-C-U-E DUE TO (c) Excess | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) None | |
| 20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE M. B. Davis | | DATE SIGNED 8/15/60 | |
| EXAMINER'S NAME (Type) Melvin B. Davis | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/16/60 | |
| 22c. NAME OF CEMETERY OR CREMATORY Baltimore National | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md | | 24a. REC'D BY REGISTRAR DATE AUG 16 '60 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur L. Kline | |



8827

CERTIFICATE OF DEATH

08793

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|---|---|
| 1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHASE MARYLAND</u> | | | | c. LENGTH OF STAY IN 1b <u>LIFE</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EBENEZER ROAD CHASE MD</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3 NAME OF DECEASED (Type or print) First Middle Last <u>MADEL F CARBACK</u> | | | | 4. DATE OF DEATH Month Day Year <u>AUGUST 23, 1960</u> | | | |
| 5 SEX <u>FEMALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8 DATE OF BIRTH <u>SEPT 2, 1872</u> | |
| 9. AGE (In years last birthday) yrs <u>87</u> | | IF UNDER 1 YEAR, IF UNDER 24 HRS Months Days Hours Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u> | |
| 11 BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>WILLIAM CARBACK</u> | | 14. MOTHER'S MAIDEN NAME <u>REBECCA COLLINS</u> | |
| 15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | INFORMANT Address <u>NORMAN CARBACK EBENEZER RD CHASE MD.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arterio-sclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>3-24</u> , 19 <u>57</u> , to <u>5-20</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>5-20</u> , 19 <u>60</u> , and that death occurred at <u>6:00 a.m.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Santi Amoroso</u> M.D. <u>6801 Belair Rd, Balto #6</u> | | | | ADDRESS (Street, city or town, state) DATE SIGNED <u>8-23-60</u> | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>AUG 25, 1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>EBENEZER CEM.</u> | | 22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MARYLAND.</u> | |
| 23 FUNERAL DIRECTOR'S SIGNATURE <u>Sassan Funeral Home, 7401 Belair Rd Balto 6.</u> | | | | ADDRESS <u>7401 Belair Rd Balto 6.</u> | | 24a. REC'D BY REG-STRAR DATE <u>AUG 25 '60</u> | |
| | | | | 24b REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: All death certificates have been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

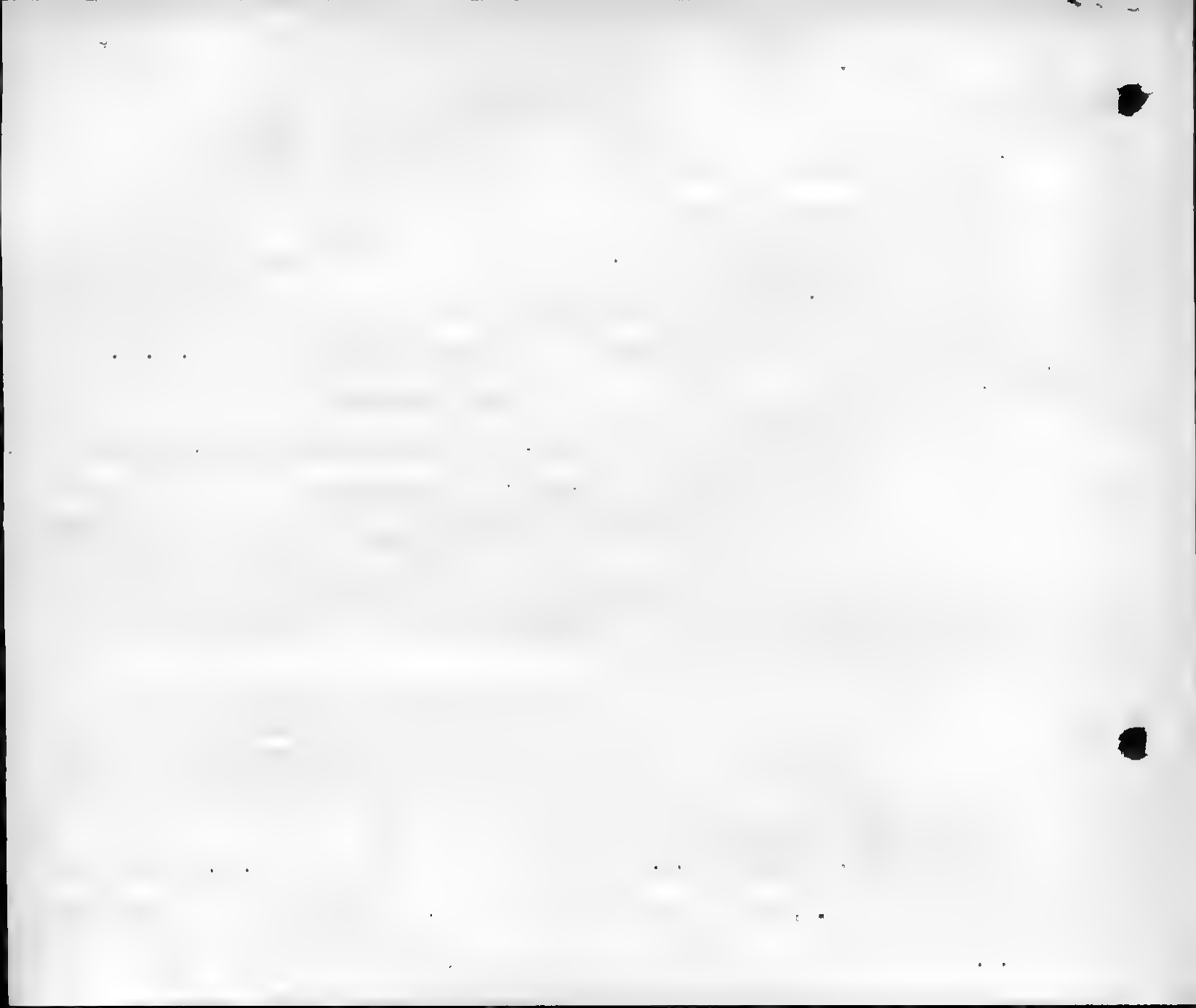
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the attending physician or attending physician may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

8823

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08794

| | | | | | | | |
|--|----------------------------------|---|--|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland | | | | c. LENGTH OF STAY IN 1b 27 Days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | e. STREET ADDRESS 700 W. 40th Street | | | |
| 3. NAME OF DECEASED (Type or print) First LEO Middle B. Last CAVEY | | | | 4. DATE OF DEATH Month August Day 31 Year 19 60 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH December 20, 1916 | 9. AGE (In years last birthday) 43 yrs | 10. IF UNDER 1 YEAR Months 43 Days 43 Hours 43 Min. | 11. IF UNDER 24 HRS Months 43 Days 43 Hours 43 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver | | 10b. KIND OF BUSINESS OR INDUSTRY Cab Company | | 11. BIRTHPLACE (State or foreign country) Ilchester, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Hugh B. Cavey | | | | 14. MOTHER'S MAIDEN NAME Nellie Frederick | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. WW II 215-10-5574 | | 17. INFORMANT Clinical Records, VAH, Balto. 18, Md. FORT HOWARD DIV. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC AND RESPIRATORY INSUFFICIENCY DUE TO GASTROINTESTINAL HEMORRHAGE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO ULCER WITH PERFORATION (DUODENAL) DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH 8 HOURS 2 WEEKS + | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple Sclerosis. Operation - Partial Gastrectomy with gastro jejunostomy - 8/23/60 | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | 20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 21. I certify that (1) (this hospital) attended the deceased from August 4, 1960 to August 31, 1960 , that (2) (we) last saw the deceased alive on August 31, 1960 , and that death occurred at 8:45 A. M. from the causes and on the date stated above | | | |
| 22a. SIGNATURE <i>Frederick S. Donaldson</i> | | 22b. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D. | | 22c. ADDRESS VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION | | 22d. DATE SIGNED 8/31/60 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Sept. 3, 1960 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem. | | 23d. LOCATION (City, town, or county) (State) Baltimore Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, 106 Columbia Rd. Ellicott City, Md. | | | | 25a. REC'D BY REG. STRAR SEP 2 '60 | | 25b. REGISTRAR'S SIGNATURE <i>Carlton S. Kiser</i> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

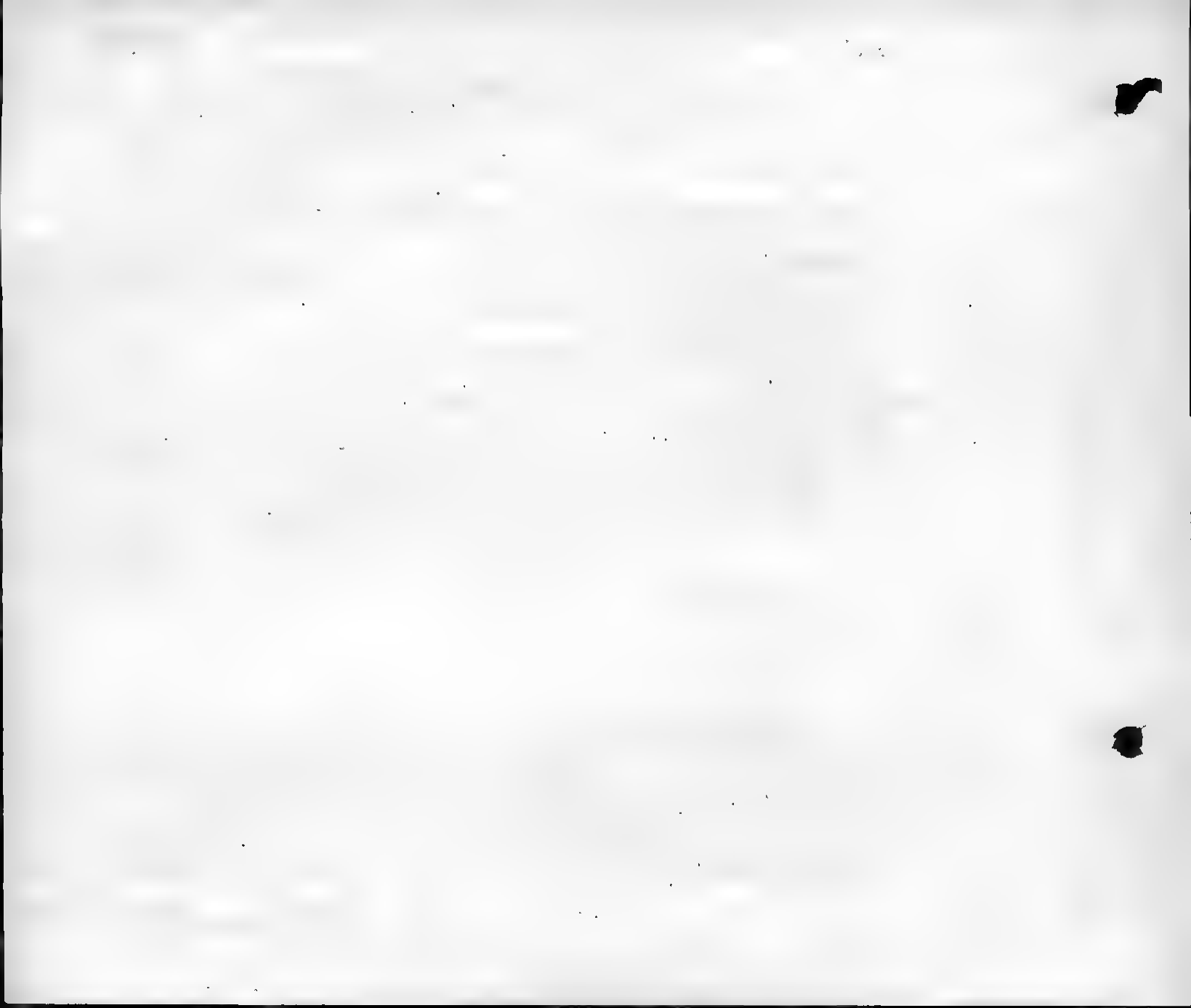
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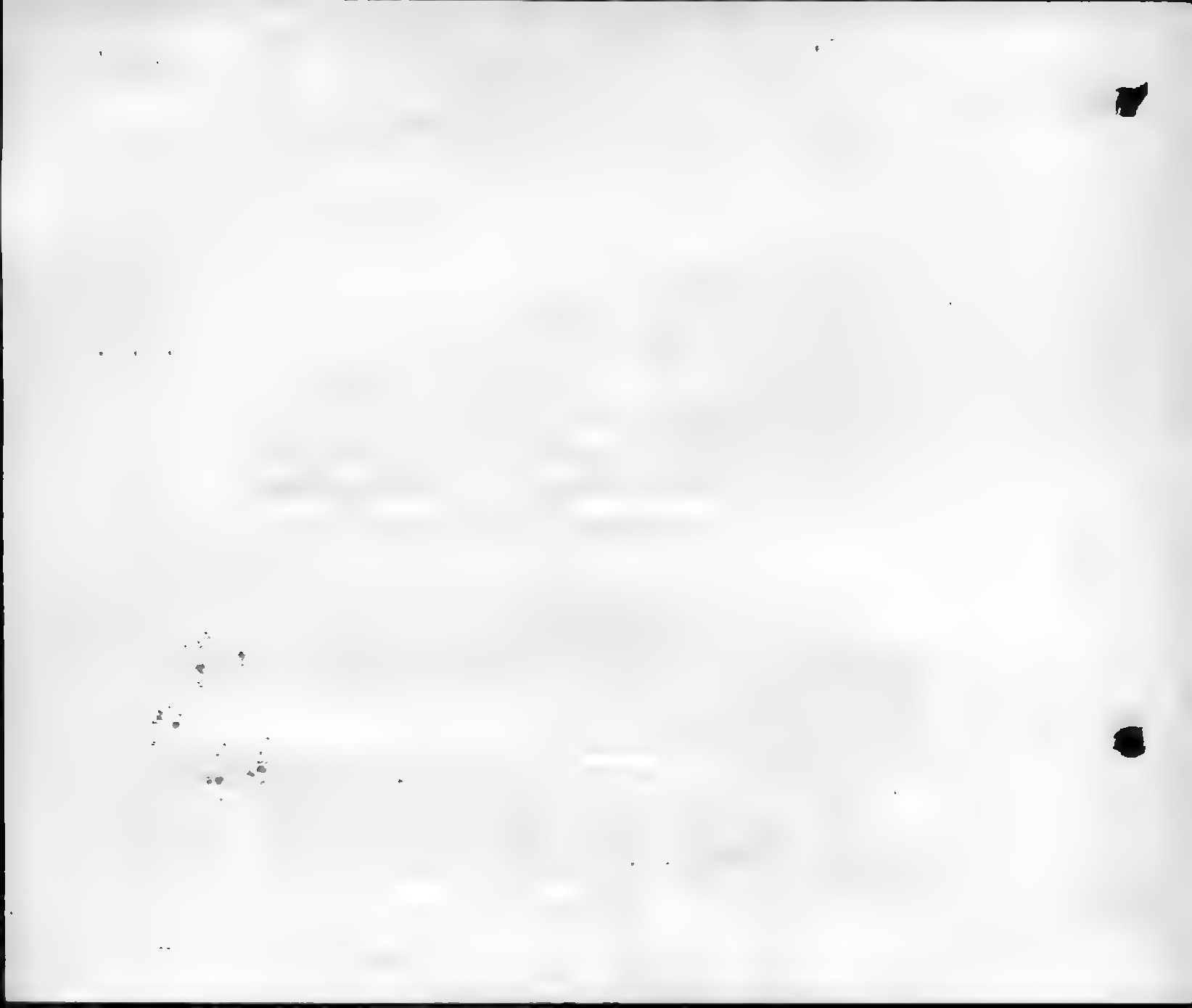
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8795

DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08795

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived. If institution on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>Halethorpe</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>Halethorpe</u> | | | |
| c. LENGTH OF STAY IN 1b <u>5 yrs.</u> | | | | d. STREET ADDRESS <u>1802 Arbutus Ave.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1802 Arbutus Ave.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3 NAME OF DECEASED (Type or print) <u>Joseph P. Clark</u> | | | | 4 DATE OF DEATH <u>Aug 1, 1960</u> | | | |
| 5 SEX <u>Male</u> | | 6 COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8 DATE OF BIRTH <u>1/1/19</u> | |
| 9. AGE (In years last birthday) <u>41</u> yrs | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Clerk</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Barton Cotton, Inc.</u> | | 11 BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12 CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | | | |
| 13 FATHER'S NAME <u>Charles Clark</u> | | | | 14 MOTHER'S MAIDEN NAME <u>Flora Breedon</u> | | | |
| 15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u> | | 16 SOCIAL SECURITY NO. <u>220-01-0338</u> | | 17. INFORMANT <u>Ruth C. Clark</u> Address <u>1802 Arbutus Ave.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | | |
| PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>11/10/1</u> | | | | | | | |
| DUE TO <u>11/10/1</u> | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>11/10/1</u> | | | | | | | |
| DUE TO <u>11/10/1</u> | | | | | | | |
| (c) <u>11/10/1</u> | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>11/10/1</u> | | | | | | | |
| 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>11/10/1</u> | |
| | | | | 20f (City or town) <u>11/10/1</u> | | (County) (State) | |
| 21 I certify that (I) (this hospital) attended the deceased from <u>11/10/1</u> to <u>11/10/1</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>11/10/1</u> 19 <u>60</u> , and that death occurred at <u>11/10/1</u> M, from the causes and on the date stated above | | | | | | | |
| 22a SIGNATURE <u>John C. Healy M.D.</u> | | | | 22b DATE SIGNED <u>11/10/1</u> | | | |
| 22c PHYSICIAN'S NAME (Type) <u>John C. Healy M.D.</u> | | | | 22d ADDRESS <u>1305 Francis Ave. 27.</u> | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b DATE THEREOF <u>8/10/60</u> | | 23c NAME OF CEMETERY OR CREMATORY <u>Balto. Nat. Cemetery Baltimore, Maryland</u> | | 23d LOCATION (City, town, or county) (State) | |
| 24 FUNERAL DIRECTOR'S SIGNATURE <u>Ambrose, Inc. 1321 Sulphur Spring Rd.</u> | | | | 25a REC'D BY REGISTRAR <u>AUG 8 '60</u> | | 25b REGISTRAR'S SIGNATURE <u>Cristina L. Hanna</u> | |





may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: At the time this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

8830

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08797

| | | | | | | | |
|--|---|---|---|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LUTHERVILLE | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LUTHERVILLE | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 16 CAVAN DRIVE | | | | e. STREET ADDRESS 16 CAVAN DRIVE | | | |
| 3. NAME OF DECEASED (Type or print) First ETHEL Middle MAUDE Last CRABBE | | | | 4. DATE OF DEATH Month AUGUST Day 9 Year 1960 | | | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH OCTOBER 7, 1888 | 9. AGE (In years last birthday) 72 yrs | IF UNDER 1 YEAR Months Days Hours Min | IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME | | 11. BIRTHPLACE (State or foreign country) CANADA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME PETER ELI | | | | 14. MOTHER'S MAIDEN NAME ESTER MC FERRAN | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO NONE | | 17. INFORMANT MISS HAZEL CRABBE | | Address 16 CAVAN DRIVE | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO (b) Myocardial Failure DUE TO (c) Rheumatoid Arthritis - Osteoporosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 mos " " | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from July 1959 to Aug 9 1960 , that (I) (we) last saw the deceased alive on Aug 2 1960 , and that death occurred at 11 AM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE George T. Gilmore | | M. D. | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> | MED. DIRECTOR <input type="checkbox"/> | STAFF PHYSICIAN <input type="checkbox"/> | 22b. DATE SIGNED 8/19/60 | |
| 22c. PHYSICIAN'S NAME (Type) GEORGE T. GILMORE | | 22d. ADDRESS Lutherville, Maryland | | | | | |
| 23a. BURIAL CREMATION BURIAL | 23b. DATE THEREOF 8/11/60 | 23c. NAME OF CEMETERY OR CREMATORY ROSE HILL BURIAL PARK | | 23d. LOCATION (City, town, or county) (State) AKRON, OHIO | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kraus | | | 25a. REC'D BY REGISTRAR DATE AUG 15 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | |



11.11.11

CERTIFICATE OF DEATH

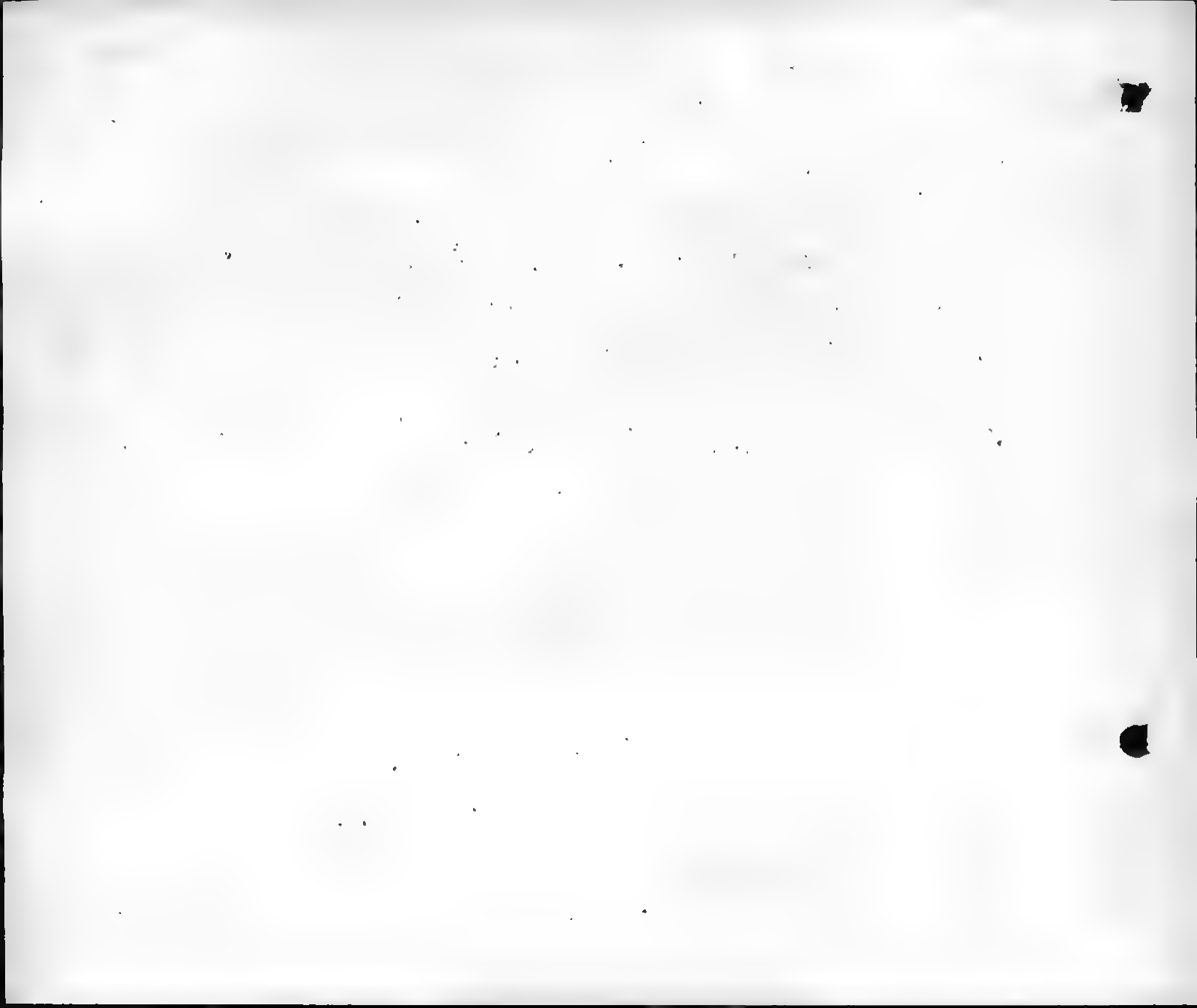
Reg. Dist. No. 08798

8831

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Freeland</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Freeland</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gore Mill Rd.</u> | | e. STREET ADDRESS <u>Gore Mill Rd</u> | |
| 3. NAME OF DECEASED (Type or print) <u>James Herbert Crawford</u> | | 4. DATE OF DEATH <u>August 10</u> 19 <u>60</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 4/1911</u> |
| 9. AGE (In years, last birthday) <u>49</u> yrs | | 10. IF UNDER 1 YEAR, IF UNDER 24 HRS | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Meatcutter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Butchering</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Mountain City, Tenn.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>James A. Crawford</u> | | 14. MOTHER'S MAIDEN NAME <u>Lelia Lefler</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>Yes</u> | | 16. SOCIAL SECURITY NO. <u>232-185033</u> | |
| 17. Informant <u>Mrs. Doris Jane Crawford, Freeland Md.</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>10-21-</u> 19 <u>57</u> , to <u>4-30-</u> 19 <u>59</u> , that I last saw the deceased alive on <u>4-30-</u> 19 <u>59</u> , and that death occurred at <u>1:00 AM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>R. Robinson</u> | | DATE SIGNED <u>8-10-60</u> | |
| PHYSICIAN'S NAME (Type) <u>R. ROBINSON</u> | | ADDRESS (Street, city or town, state) <u>New Freedom, Pa.</u> | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>8-13-60</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>MIDDLETOWN CEMETERY</u> | 22d. LOCATION (City, town or county) (State) <u>Balto. Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob H. Heston</u> | | 24a. REC'D BY REGISTRAR <u>Arthur S. Heston</u> | |
| ADDRESS <u>New Freedom, Pa.</u> | | DATE <u>AUG 18 '60</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of time death.



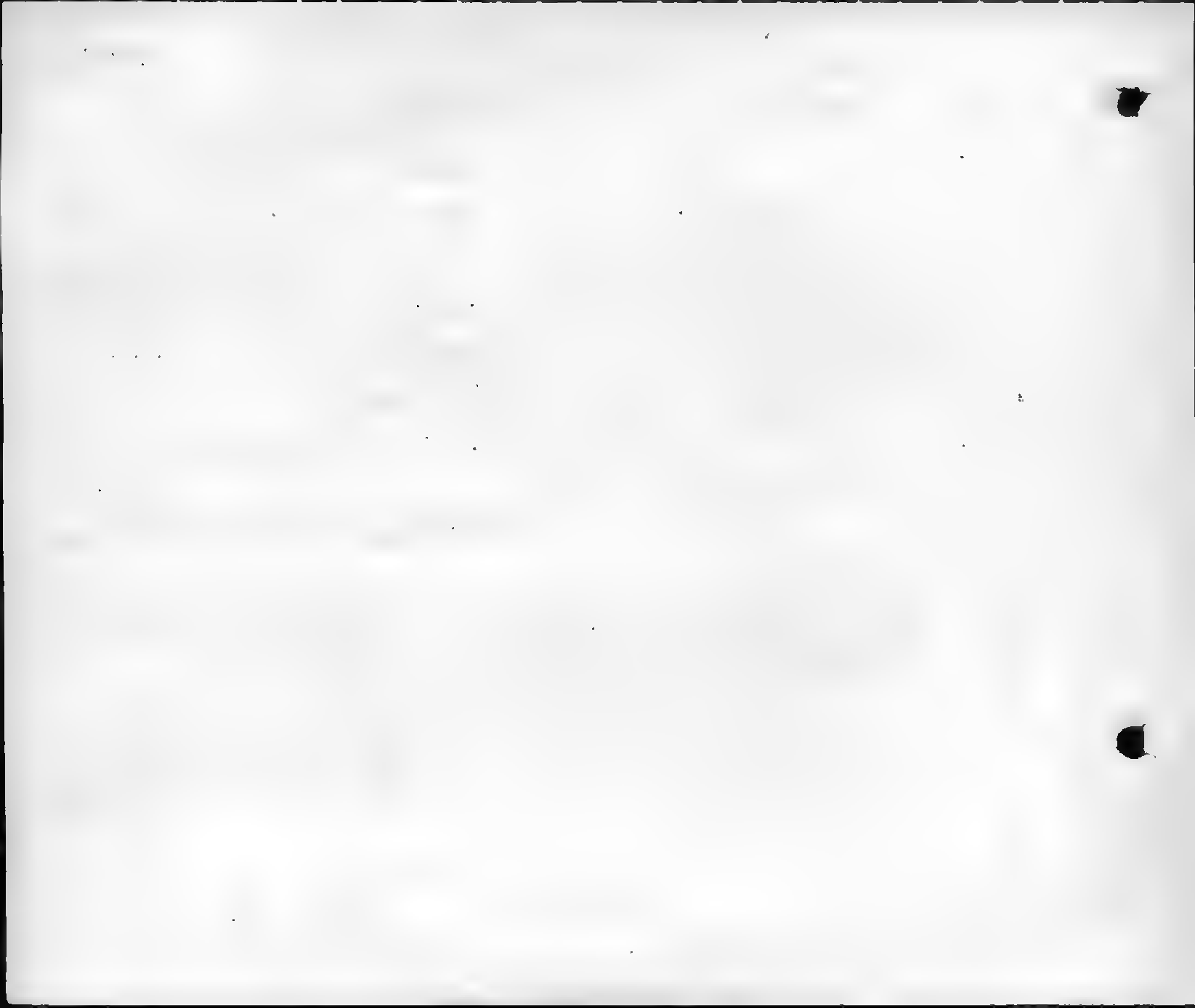
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8791

08799

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 115 Patapsco Ave. | | d. STREET ADDRESS 115 Patapsco Ave. | |
| 3. NAME OF DECEASED (Type or print) First ANNA Middle KATHERINE Last DAIL | | 4. DATE OF DEATH Month August Day 22 Year 1960 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 3, 1891 |
| 9. AGE (In years last birthday) 69 | | 10. IF UNDER 1 YEAR: Months 6 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William Henry Thorn | | 14. MOTHER'S MAIDEN NAME Cassie Thomas | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No. | | 16. SOCIAL SECURITY NO | |
| 17. INFORMANT Howard T. Dail 2903 Dunbrin Road | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia 442X DUE TO (b) Hyper tension Cardiac Vase Renal dis Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus | | | |
| INTERVAL BETWEEN ONSET AND DEATH 6 days 6 years | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 6-52 to 8-22 , 19 60 , that (I) (we) last saw the deceased alive on 8-22 , 19 60 , and that death occurred at 1:30 P M, from the causes and on the date stated above | | | |
| 22a. SIGNATURE Jack C Collins | | 22b. DATE SIGNED 8-23-60 | |
| 22c. PHYSICIAN'S NAME (Type) JACK C COLLINS | | 22d. ADDRESS 2 Kinslip BALT. 22 Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8/25/60 | |
| 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | 23d. LOCATION (City, town, or county) (State) Parkville, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home Dundalk, Md. | | 25a. REC'D BY REGISTRAR DATE AUG 24 '60 | |
| 25b. REGISTRAR'S SIGNATURE Carlton S. Kline | | | |

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



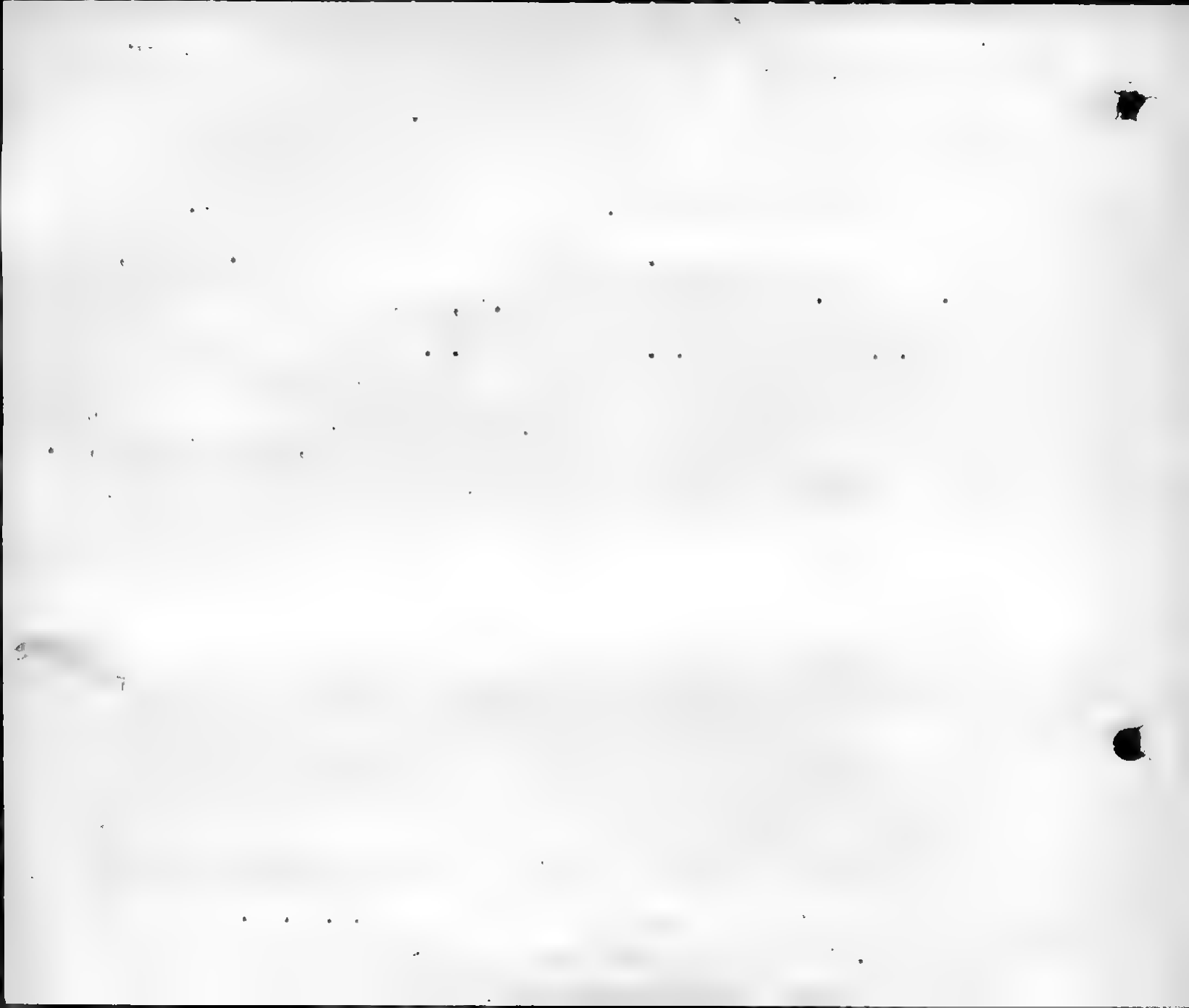
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15M 9/59

CERTIFICATE OF DEATH

8832

08800

| | | | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | Baltimore | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission) a. STATE | | Md. | | b. COUNTY | | 1 | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | Catonsville Manor | | c. LENGTH OF STAY IN 1b | | 12 yrs | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | Catonsville Manor | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | 5903 Queen Anne St. | | 4. STREET ADDRESS | | 5903 Queen Anne St. | | e. IS RESIDENCE ON A FARM? | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | | First | | Middle | | Last | | 4. DATE OF DEATH | | Month | | Day Year | |
| Alice | | R. | | Dapkunas | | | | Aug. | | 30, | | 1960 | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (in years last birthday) | | 10. IF UNDER 1 YEAR | | 10. IF UNDER 24 MRS | |
| F. | | W. | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Mar. 10, 1912 | | 48 yrs | | Months Days | | Hours Min | |
| 10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | | | | | |
| H.W. | | O.H. | | N.J. | | USA | | | | | | | |
| 13. FATHER'S NAME | | Max Kohn | | 14. MOTHER'S MAIDEN NAME | | Jeannie Purdy | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO | | 17. INFORMANT | | Address | | | | | | | |
| No | | | | Mr. Stanley Dapkunas | | 5903 Queen Anne St., Catonsville 28, Md. | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | Bronchiogenic carcinoma | | INTERVAL BETWEEN ONSET AND DEATH | | 6 mo. | | | | | |
| | | DUE TO | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | (b) | | DUE TO | | | | | | | | | |
| | | (c) | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year | | 20d. INJURY OCCURRED | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | | | |
| Hour a. m. p. m. | | While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 7-16-1960 to Aug 30, 1960 that (I) (we) last saw the deceased alive on Aug 30, 1960, and that death occurred at 11:55 PM on the causes and on the date stated above | | | | | | | | | | | | | |
| 22a. SIGNATURE | | Katharine V. Kemp | | M.D. | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22b. ADDRESS | | 722 Stamford Rd Baltimore | | 22c. DATE SIGNED 9/1/60 | |
| 22c. PHYSICIAN'S NAME (Type) | | Katharine V. Kemp M.D. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) | | (State) | | | | | |
| Burial | | 9/3/60 | | Meadowridge Cemty | | A.A.Co.Md. | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Witzke Fun. Dir. 4101 Edmondson Ave | | | | DATE SEP 1 '60 | | Charles E. Hines | | | | | | | |



8832

08801

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | 2. USUAL RESIDENCE (Where deceased lived. If institut on Residence before admiss on) a. STATE Md. b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Baltimore | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INST TUTION 1228 Leeds Terrace #27 | | d. STREET ADDRESS 1228 Leeds Terrace #27 | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First C. Middle Howard Last Darling | | 4. DATE OF DEATH Month Aug. Day 3, Year 1960 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 4, 1883 |
| 9. AGE (In years last birthday) yrs 77 | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret. carrier | | 10b. KIND OF BUSINESS OR INDUSTRY Sunpaper | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | |
| 13. FATHER'S NAME Charles Wesley | | 14. MOTHER'S MAIDEN NAME Mary E. Smith | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO 219-32-1931 | |
| 17. INFORMANT Nellie F. Darling | | Address 1228 Leeds Terrace #27 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cancer of Prostate DUE TO Prostate Cancer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction DUE TO Myocardial infarction DUE TO Myocardial infarction PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 yrs INTERVAL BETWEEN ONSET AND DEATH 1 yr 2 6 mo | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from May 1957 to Aug. 3, 1960 that (I) (we) last saw the deceased alive on Aug. 3, 1960 and that death occurred at 8 a.m. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE B. Brumbaugh M.D. | | 22b. DATE SIGNED 8/4/60 | |
| 22c. PHYSICIAN'S NAME (Type) Bruce Brumbaugh, M.D. | | 22d. ADDRESS 5609 Main Street, Elkridge, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8/6/60 | |
| 23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery Baltimore, Maryland | | 23d. LOCATION (City, town, or county) (State) | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard | | 25a. REC'D BY REGISTRAR DATE AUG 5 '60 | |
| ADDRESS 4107 Wilkens Avenue | | 25b. REGISTRAR'S SIGNATURE Arthur S. Hines | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
TSM 9/59

1

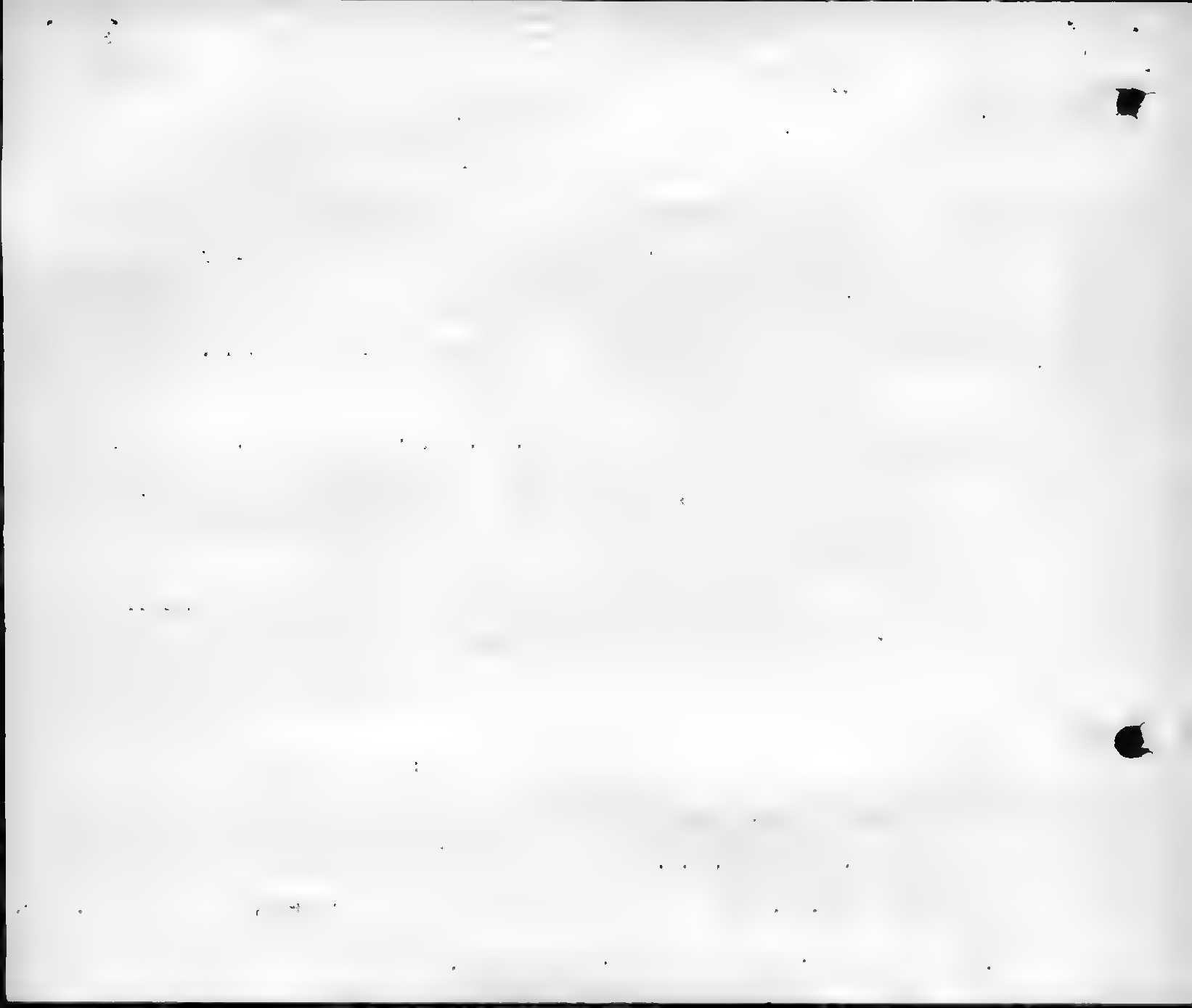
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8834

CERTIFICATE OF DEATH

08802

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland c. LENGTH OF STAY IN 1b 4 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | 2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Colombia, South America b. COUNTY Cartagena c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cartagena d. STREET ADDRESS Calle Baloco # 7-48 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last HORTENSIA NUNEZ de CALVO | | | | 4. DATE OF DEATH Month Day Year August 15 1960 | | | |
| 5 SEX FEMALE | | 6 COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8 DATE OF BIRTH April 13, 1901 | |
| 9 AGE (In years lost birthday) 59 yrs | | IF UNDER 1 YEAR Months Days Hours Min | | IF UNDER 24 HRS Hours Min | | | |
| 10a. USULA OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Barraquilla, Colombia, S.A. Colombia | |
| 12 CITIZEN OF WHAT COUNTRY? Colombia | | | | | | | |
| 13. FATHER'S NAME Agustiu Nunez | | | | 14. MOTHER'S MAIDEN NAME Clementina Nunez | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO --- | | 17 INFORMANT Clin. Rec. VAH, Baltimore 18, Md., Fort Howard Division | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) TUMOR, LEFT FRONTAL LOBE, UNSPECIFIED DUE TO (b) _____ DUE TO (c) _____ Conditions, if any which gave rise to immediate cause (c), stating the underlying cause lost. | | | | | | INTERVAL BETWEEN ONSET AND DEATH UNKNOWN | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVING RISE TO DEATH Status following operation-radical mastectomy, left for carcinoma of breast Operation-8/11/60 left prefrontal lobectomy, tumor left frontal lobe | | | | | | WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21 I certify that (x) (this hospital) attended the deceased from August 11, 1960 to August 15, 1960 , that (x) (we) last saw the deceased alive on August 15, 1960 , and that death occurred at 9:25 A.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <i>Frederick S. Donaldson</i> M.D. | | | | 22b. DATE 8/15/60 | | 22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D. | |
| 22d. ADDRESS VAH, BALTO. 18, MD., FORT HOWARD DIVISION | | | | | | | |
| 23a. BURIAL CREMATION REMOVAL (Specify) Removal | | 23b. DATE THEREOF Aug. 19, 1960 | | 23c. NAME OF CEMETERY OR CREMATORY Municipal Cemetery | | 23d. LOCATION (City, town, or county) (State) Cartagena, Colombia, So. Amer. | |
| 24 FUNERAL DIRECTOR'S SIGNATURE Wm. Cook | | | | ADDRESS Blight, Inc. 6009 Harford Rd. Baltimore, Md. | | 25a. REC'D BY REGISTRAR DATE AUG 24 '60 | |
| | | | | 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Knecht</i> | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08803

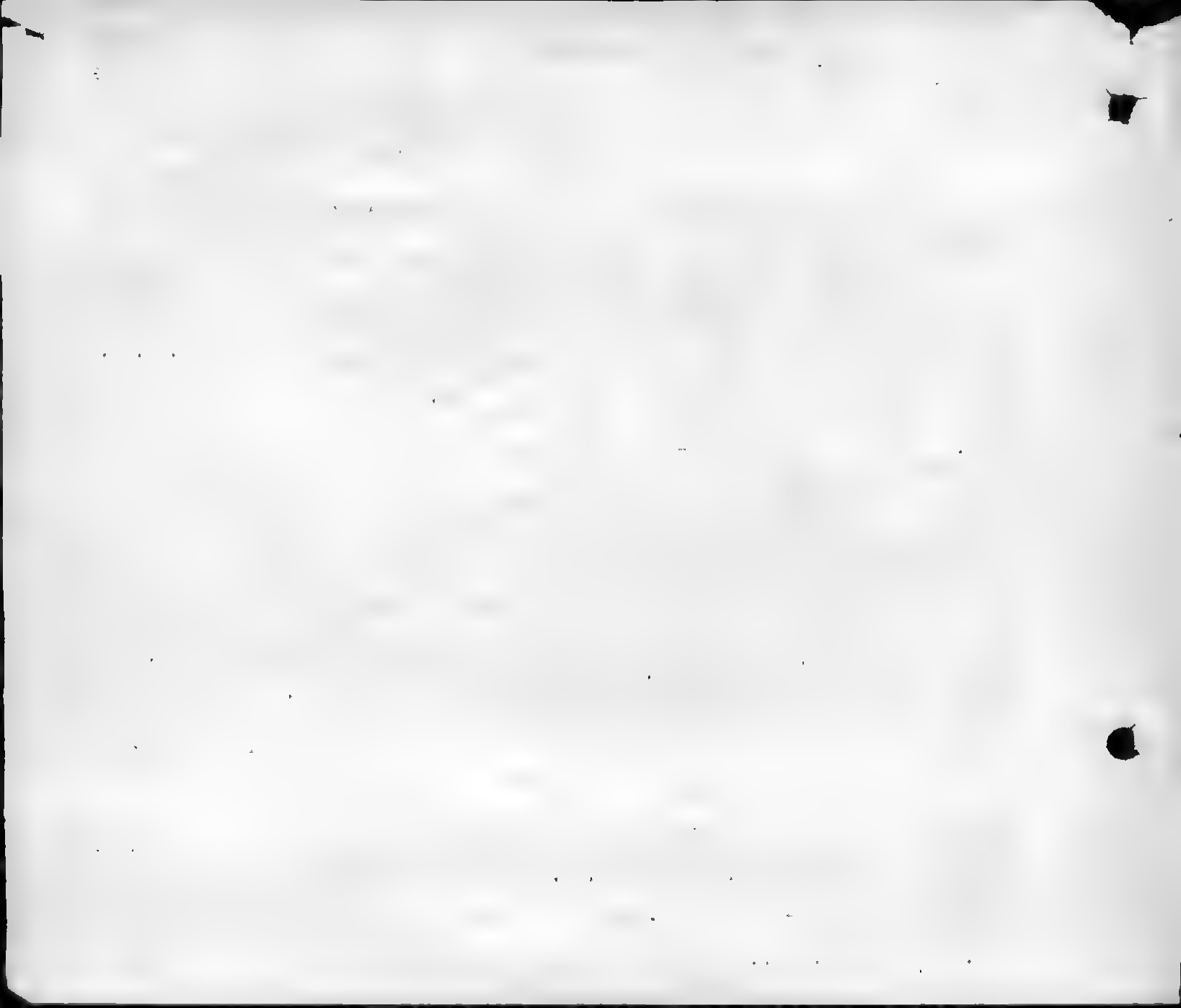
8835

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

| | | | |
|--|-----------------------|--|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived If inst'l on Residence before admision) a STATE Maryland b COUNTY | |
| b CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Catonsville | | c LENGTH OF STAY IN 1b 6yr2mth29dys | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL | | e STREET ADDRESS 36 Hathaway Road | |
| 3 NAME OF DECEASED (Type or print) Gabriel Dieumegarde | | 4 DATE OF DEATH August 14 19 60 | |
| 5. SEX male | 6 COLOR OR RACE white | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH October 3, 1903 56 yrs |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) plumber | | 10b KIND OF BUSINESS OR INDUSTRY | |
| 11 BIRTHPLACE (State or foreign country) Pennsylvania | | 12 CITIZEN OF WHAT COUNTRY U. S. A. | |
| 3. FATHER'S NAME Louis Dieumegarde | | 14 MOTHER'S MAIDEN NAME Marie Lavale | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Nat. Guard | | 16 SOCIAL SECURITY NO 216-07-8761 | |
| 17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxiation | | | |
| DUE TO (b) Foreign body found in mouth and esophagus and larynx | | | |
| DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) At 5:30 p. m. on 8-14-60 pt. was found dead abed with pieces of bread in his mouth and in the upper opening of the esophagus. | |
| 20c. TIME OF INJURY Month, Day, Year Hour 5:30 p.m. 8-14 19 60 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg., etc.) Hospital Catonsville 28, Maryland | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <i>George M. Kieffer</i> | | DATE SIGNED 8-15-60 | |
| EXAMINER'S NAME (Type) George M. Kieffer, M. D. | | M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 8-17-60 | |
| 22c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery | | 22d. LOCATION (City, town, or county) (State) Texas, Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, Inc., 1050 York Road, Towson | | 24a. REC'D BY REGISTRAR DATE AUG 16 '60 | |
| | | 24b. REGISTRAR'S SIGNATURE <i>Charles E. Kinner</i> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FUNERAL DIRECTOR: At [redacted] this certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

08804

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|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE Maryland | | b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 7 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | 201-1 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | | | d. STREET ADDRESS 3920 Fernhill Avenue | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | | First Edward | | Middle M. | | Last Ditch Sr. | |
| 5. SEX male | | 6. COLOR OR RACE white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH June 28, 1888 | |
| 9. AGE (in years, last birthday) 72 | | 10. UNDER 1 YEAR Months 1 | | 11. UNDER 24 HRS Days 1 | | 12. UNDER 24 HRS Hours 1 | |
| 10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) stage employee | | 10b. KIND OF BUSINESS OR INDUSTRY stage | | 11. BIRTHPLACE (State - foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Unknown Daniel Ditch | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown | | 16. SOCIAL SECURITY NO. 213-09-5817 | | 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebral vascular accident DUE TO (c) Arteriosclerotic cardiovascular disease | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from July 22, 1960 to Aug. 1, 1960 , that (I) (we) last saw the deceased alive on Aug. 1, 1960 , and that death occurred at 10:25a M, from the causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE Stella Wachslar, M.D. | | | | 22b. DATE SIGNED 8-1-60 | | | |
| 22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. | | | | 22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland | | | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) Cremation | | 23b. DATE THEREOF Aug. 3, 1960 | | 23c. NAME OF CEMETERY OR CREMATORY Greenmount | | 23d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Burgee Funeral Home | | | | 25a. REC'D BY REGISTRAR 3631 Falls Road | | | |
| 25b. REGISTRAR'S SIGNATURE AUG 3 '60 | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8837

08895

| | | | |
|---|----------------------------------|--|----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonville | | c. LENGTH OF STAY IN 1b 2 Days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Richard Middle Paul Last Dorman | | 4. DATE OF DEATH Month August Day 17 Year 19 60 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1897? |
| 9. AGE (In years last birthday) 63 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Unknown | | 12. CITIZEN OF WHAT COUNTRY? U/ S. A. | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) unknown | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | |
| PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 331X DUE TO (c) | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Aug. 15 1960 to Aug. 17 1960 that (I) (we) last saw the deceased alive on Aug. 17 1960 and that death occurred at 8:25 M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Imre Kopits | | 22b. DATE SIGNED 8-17-60 | |
| 22c. PHYSICIAN'S NAME (Type) Imre Kopits, M. D. | | 22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonville 28, Maryland | |
| 23a. BURIAL CREMATION, (Specify) CREMATION | | 23b. DATE THEREOF 8-19-60 | |
| 23c. NAME OF CEMETERY OR CREMATORY GREENMOUNT | | 23d. LOCATION (City, town, or county) (State) BALTIMORE, MD | |
| 24. FUNERAL DIRECTOR'S SIGNATURE WM COOK INC. | | 25a. REC'D BY REGISTRAR AUG 22 '60 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Kline | | | |





Burial ^{REMOVAL (Specify)} Transit

P. K. Yip, M.D.

25a. REC'D BY REGISTRAR
AUG 19 '60
DATE

REGISTRAR'S SIGNATURE
C. L. House

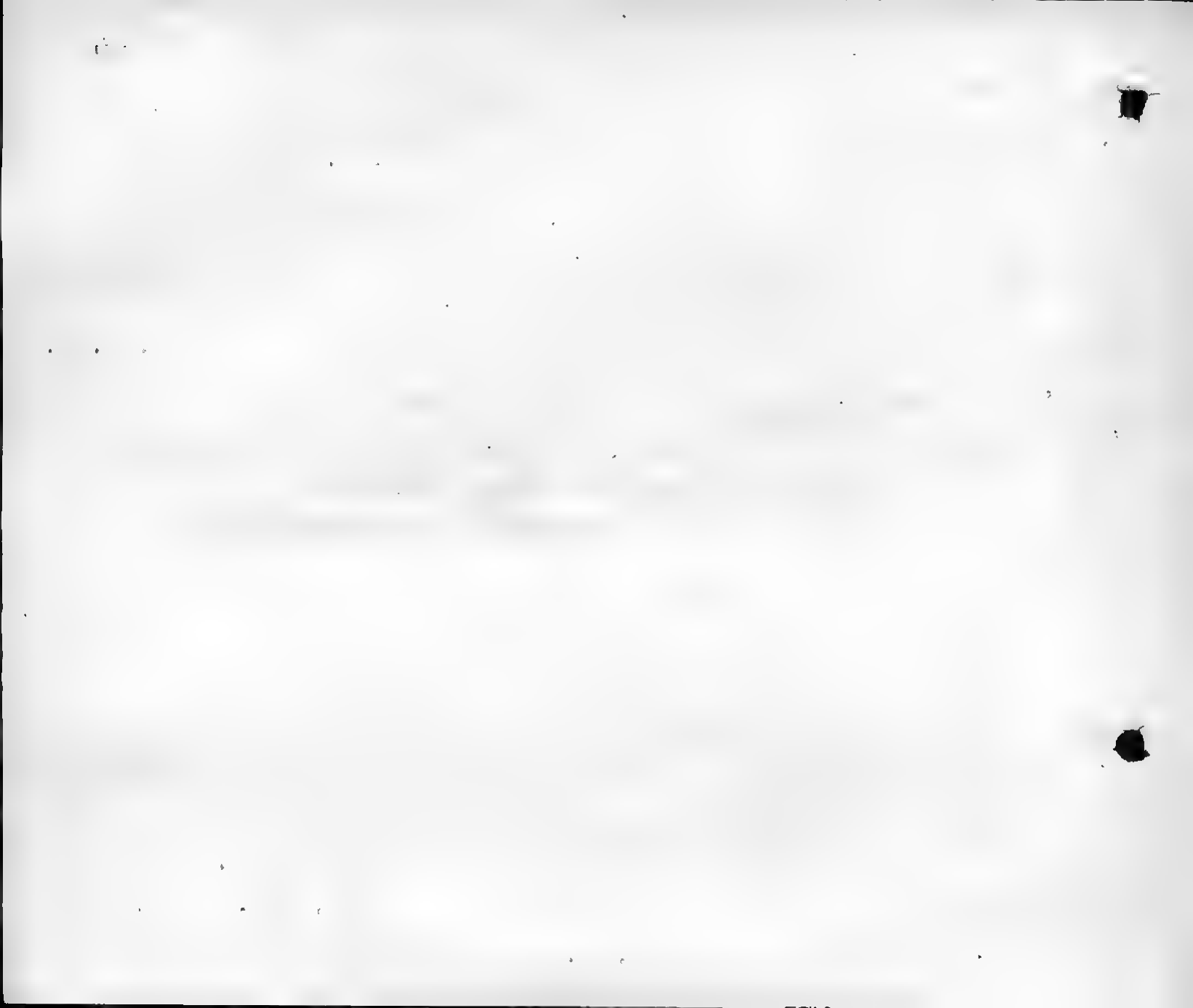
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8838

08896

| | | | | | | | |
|---|----------------------------------|---|--|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived - If institution on - Residence before admission) a. STATE Maryland | | b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits write RURAL, and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 3month 22days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carollton, Md. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital | | | | d. STREET ADDRESS 8404 Fremont Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Nellie | | First Margaret | | Last Doyle | | 4. DATE OF DEATH Month August Day 13 Year 1960 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 29, 1872 | | 9. AGE (In years last birthday) 88 yrs | F UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Massachusetts | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Timothy Reardon | | | | 14. MOTHER'S MAIDEN NAME Johanna Riley | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) unknown | | 16. SOCIAL SECURITY NO unknown | | 17. INFORMANT Records: Spring Grove State Hospital | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.1 CONGESTIVE HEART FAILURE DUE TO (b) ARTEROSCLEROTIC CARDIAC VASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from July 20 1960 , to 1960 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at M , from the causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE P. K. Yip | | | | ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) P. K. Yip, M.D. | | | | 22d. ADDRESS Spring Grove State Hospital Catonsville, Md. | | | |
| 23a. BURIAL CREMATION Removal (Specify) | | 23b. DATE THEREOF 8/17/60 | | 23c. NAME OF CEMETERY OR CREMATORY Adams Cemetery | | 23d. LOCATION (City, town, or county) (State) Adams, Mass. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons | | | | ADDRESS Hyattsville, Md. | | 25a. REC'D BY REGISTRAR DATE AUG 19 1960 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Hanna | | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

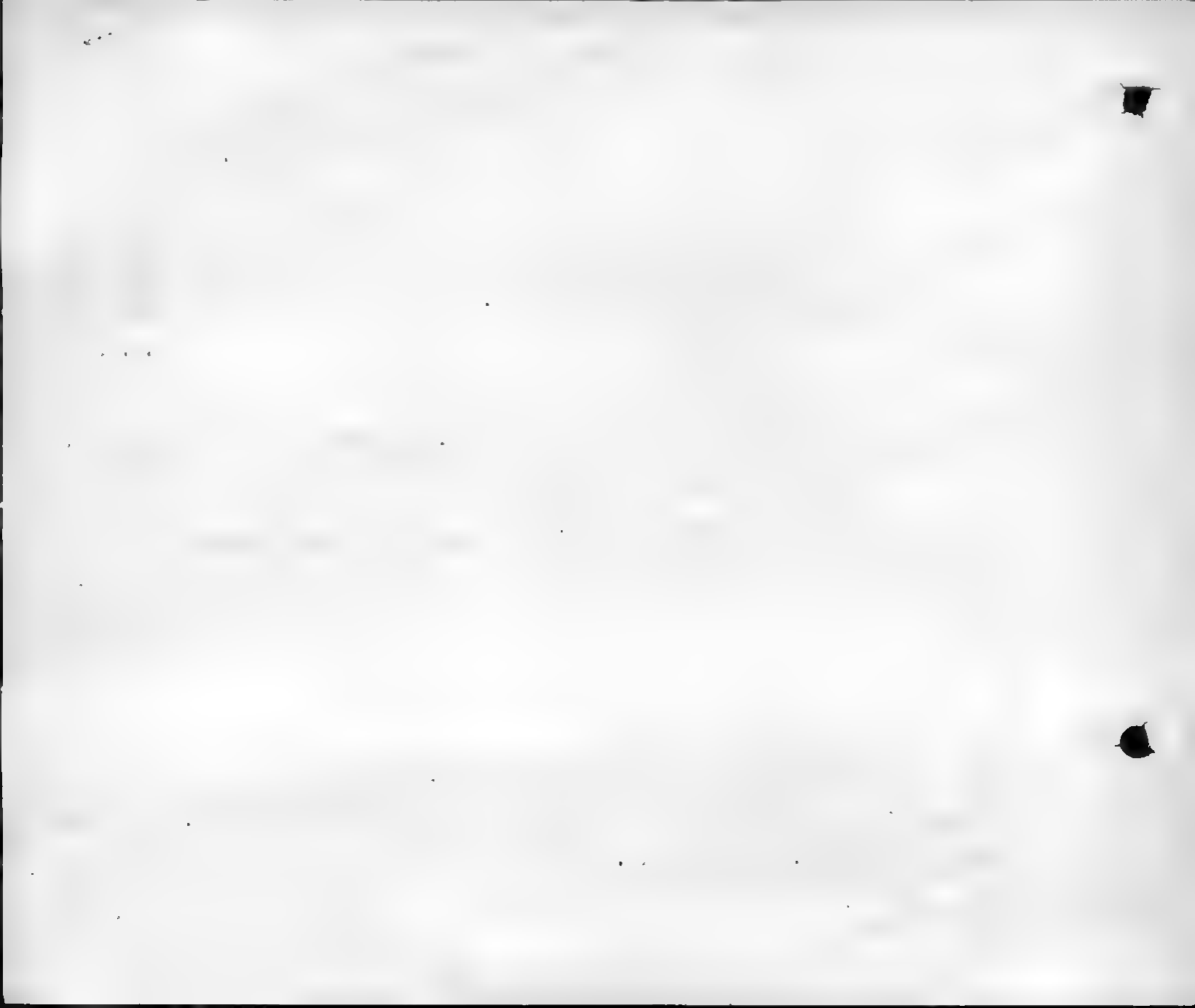
Reg. Dist. No.

08807

8839

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenarm Road | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Sister Mary Anacleto Drescher | | | | 4. DATE OF DEATH Month Day Year August 30 19 60 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Dec. 6, 1876 | |
| 9. AGE (In years last birthday) 84 yrs. | | IF UNDER 1 YEAR Months Days Hours Min | | IF UNDER 24 HRS Months Days Hours Min | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Bavaria, Germany | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME George Drescher | | | | 14. MOTHER'S MAIDEN NAME Eva Tatis | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Sister M. Peter Fourier Notch Cliff, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arterio - sclerosis - hypertensive DUE TO (c) uremia | | | | INTERVAL BETWEEN ONSET AND DEATH 4 days 10 yrs. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) Towson | | | | 20g. (County) Notch Cliff | | 20h. (State) Md. | |
| 21. I certify that I attended the deceased from April 19 60 to August 19 60 , that I last saw the deceased alive on August 25 19 60 and that death occurred at 6:55 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>Charles F. O'Donnell</i> M.D. | | | | DATE SIGNED 8/30/60 | | | |
| PHYSICIAN'S NAME (Type) Charles F. O'Donnell M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 9-1-60. | | 22c. NAME OF CEMETERY OR CREMATORY VILLA MARIA CEM. | | 22d. LOCATION (City, town, or county) (State) NOTCH CLIFF NR TOWSON, MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles L. Seiler</i> | | | | ADDRESS 9015 CONKLING ST. BALTO., 24, MD. | | 24a. REC'D BY REGISTRAR SEP 2 '60 | |
| | | | | 24b. REGISTRAR'S SIGNATURE <i>Carlton S. Thomas</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



08808

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. _____ Page 4
may be retained by the _____ or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15 (4)
15M 9/58



STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Filed 11-13-60 at

8841

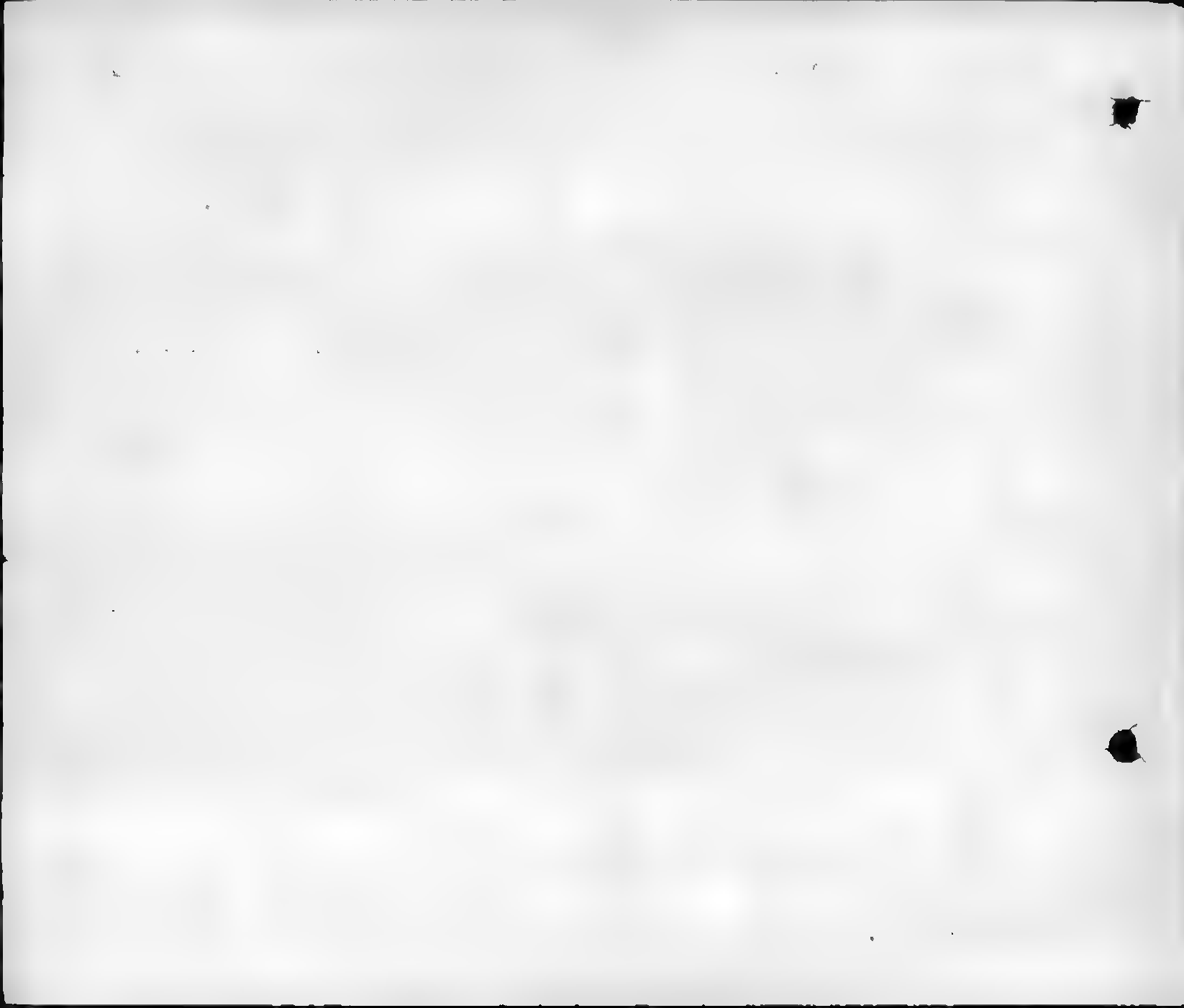
CERTIFICATE OF DEATH

Reg. Dist. No.

08809

| | | | |
|---|-------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1107 Wilkins Avenue 1002 N. Holling Road | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home | | d. STREET ADDRESS Baltimore, Md. | |
| 3. NAME OF DECEASED (Type or print) First CATHERINE Middle ANNE Last DUVALL | | 4. DATE OF DEATH Month August Day 28 Year 1960 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4/30/1870 |
| 9. AGE (In years last birthday) 90 | | IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY at home | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME David Bowen | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Gordon S. Duvall, son, 2631 Chesterfield Ave | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 3 yrs + | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Canceroma, rt. upper eye lid | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 1960 to 28 Aug. 1960 , that I last saw the deceased alive on 27 Aug. 1960 , and that death occurred at 9⁰⁰ A. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE John A. Nesbitt, Jr. M.D. | | ADDRESS (Street, city or town, state) 1118 St Paul St. DATE SIGNED 8-29-60 | |
| PHYSICIAN'S NAME (Type) JOHNA. NESBITT, JR. | | Baltimore 2, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 8/31/60 | 22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | 22d. LOCATION (City, town, or county) (State) Baltimore, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek | | 24a. REC'D BY REGISTRAR DATE AUG 30 '60 | |
| ADDRESS 3331 Brehms Lane | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kneass | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

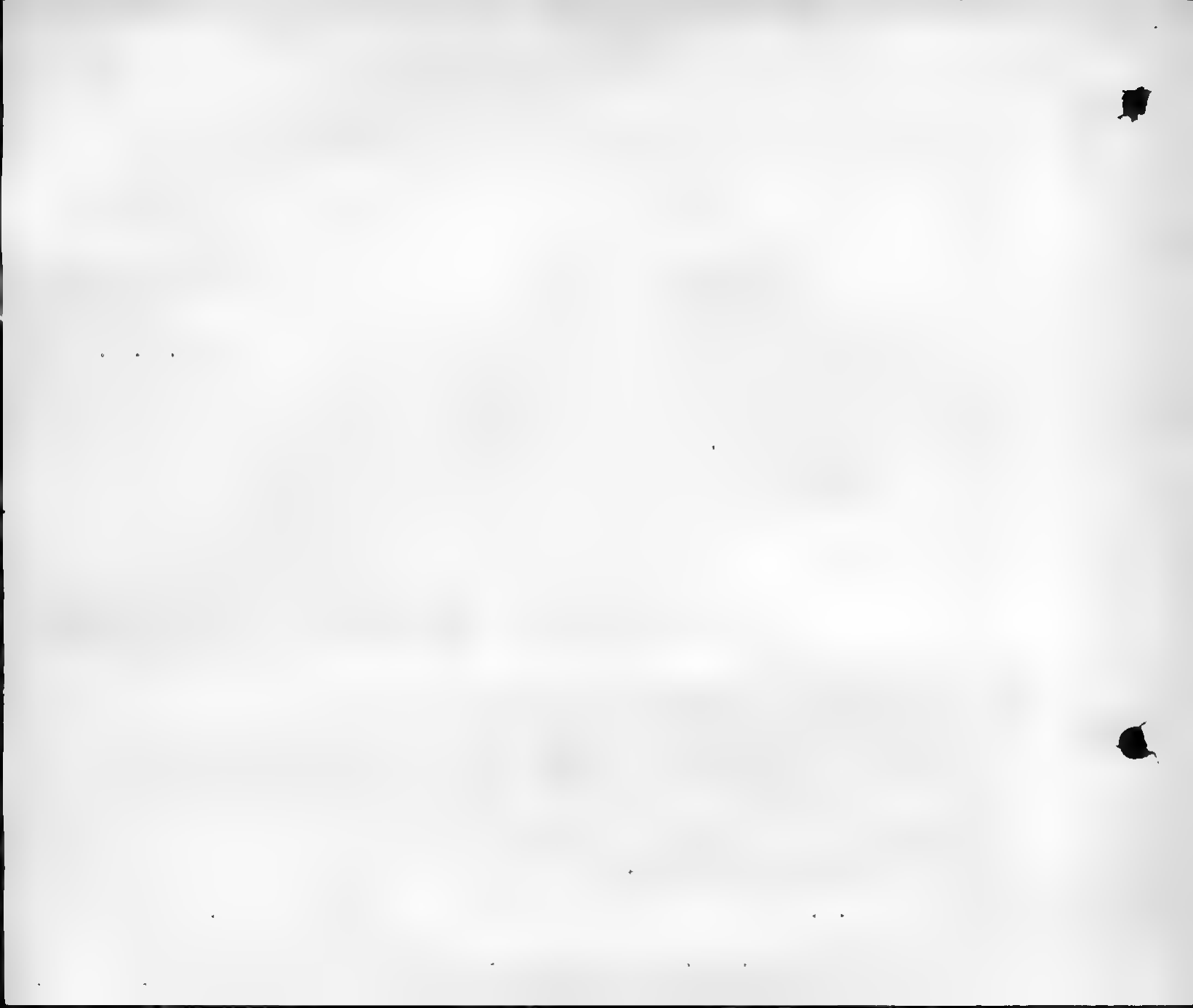
8842

CERTIFICATE OF DEATH

Reg. Dist. No. 18810

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before adm ss on) a. STATE Maryland b. COUNTY Anne Arundel | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie | |
| d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Beulah Middle Ruth Last Edwards | | 4. DATE OF DEATH Month 8 Day 4 Year 1960 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 3, 1891 |
| 9. AGE (In years last birthday) yrs 69 | | 10. IF UNDER 1 YEAR Months Days Hours M n. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME UNKNOWN George Reighter | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) unknown | | 16. SOCIAL SECURITY NO unknown | |
| 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Diaphragmatic Myocardial Infarction | | | |
| 420.1 DUE TO | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | |
| (b) DUE TO | | | |
| (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 3, 1960 to August 4, 1960 , that I last saw the deceased alive on August 4, 1960 , and that death occurred at 3:30 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Stella Wachslar | | DATE SIGNED 8-4-60 | |
| PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. | | ADDRESS Catonsville 28, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Aug. 8, 1960 | |
| 22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | 22d. LOCATION (City, town, or county) (State) Baltimore Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS, INC. | | ADDRESS Baltimore Md. | |
| 24a. REC'D BY REGISTRAR AUG 8 '60 | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4, 5, and 6 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8843

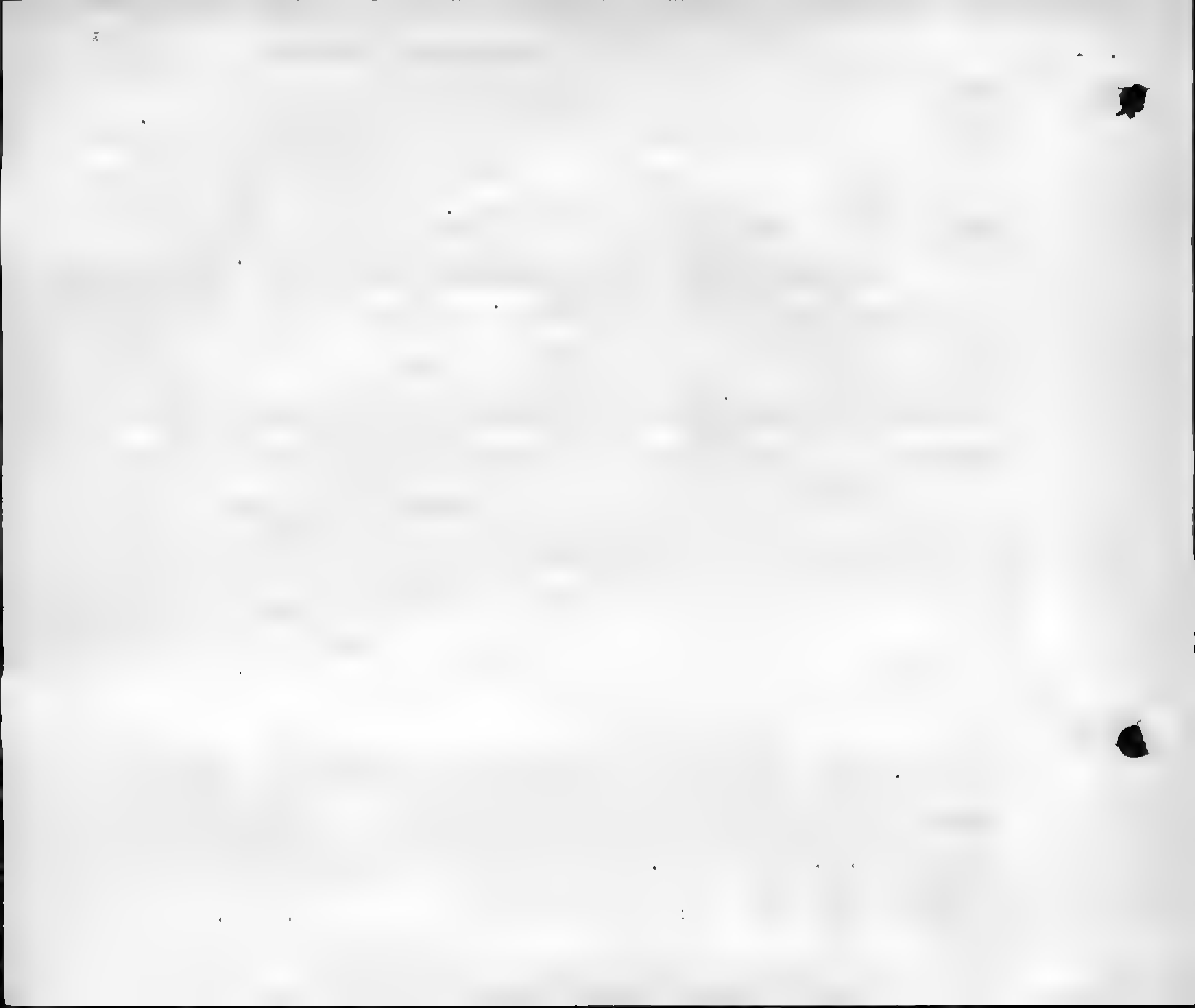
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08811

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>815 S. Marwick Ave</u> | | e. STREET ADDRESS <u>815 S. Marwick Ave</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Frank Edward Engler Sr</u> | | 4. DATE OF DEATH Month Day Year <u>Aug. 22, 1960</u> <u>19</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct. 16, 1908</u> |
| 9. AGE (In years last birthday) <u>51</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min | IF UNDER 24 HRS. Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Bellevue Hospital</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>ENGLE</u> | | 14. MOTHER'S MAIDEN NAME <u>Winnie E. Engler</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>115-05-8696</u> | |
| 17. INFORMANT <u>Anna M Engler - Stranich</u> | | Address <u>815 S. Marwick Ave</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> | | | |
| DUE TO (b) <u>Cardio vascular heart disease</u> | | | |
| DUE TO (c) _____ | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>Geo. S. Kieffer</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>Geo. S. Kieffer M.D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>8/25/60</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u> | | ADDRESS <u>4107 Wilkens Ave.</u> | |
| 24a. REC'D BY REGISTRAR <u>Aug 20 60</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. H. S. Hubbard</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8792

CERTIFICATE OF DEATH

08812

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|--|---|--|---|--|
| 1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 23 PORTSHIP ROAD | | | | d. STREET ADDRESS 23 PORTSHIP ROAD | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last DAVID L. EVANS | | | | 4. DATE OF DEATH Month Day Year AUGUST 5 1960 | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JUNE 29, 1910 | 9. AGE (In years, lost birthday) 50 yrs | IF UNDER 1 YEAR Months Days Hours Min | IF UNDER 24 HRS Hours Min | 10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN | | 10b. KIND OF BUSINESS OR INDUSTRY SHIPYARD | | 11. BIRTHPLACE (State or foreign country) WEST VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME LOUIS EVANS | | | | 14. MOTHER'S MAIDEN NAME SARAH JANE REESE | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 213-07-4546 | | INFORMANT Address MRS MARY EVANS - 23 PORTSHIP | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 416X RHEUMATIC HEART DISEASE DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH 8 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. _____ 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Nov. 2, 1955 to Aug 5, 1960 , that I last saw the deceased alive on Aug 5, 1960 , and that death occurred at 11¹⁰ PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1 LIBERTY PARKWAY DATE SIGNED Aug 6, 1960 | | | | | | | |
| ACTUAL SIGNATURE E. R. Evans | | M.D. 1 LIBERTY PARKWAY | | | | | |
| PHYSICIAN'S NAME (Type) E. R. EVANS | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF AUG 9 1960 | | 22c. NAME OF CEMETERY OR CREMATORY OAK LAWN | | 22d. LOCATION (City, town, or county) (State) COLLEGE MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ULLRICH FUNERAL HOME - DUNDALK MD | | | | 24a. REC'D BY REGISTRAR AUG 9 '60 | | 24b. REGISTRAR'S SIGNATURE Charles L. Hume | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3, Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08813

Reg. Dist. No.

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>BALTIMORE</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>25 Cottage Ave.</u> | | d. STREET ADDRESS <u>25 Cottage Ave.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Elizabeth</u> First Middle Last | | 4. DATE OF DEATH <u>8-31-1960</u> Month Day Year | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Colored</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8-15-1886</u> |
| 9. AGE (In years last birthday) <u>74</u> yrs. | | 10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Prince Edward Co., Va.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Josh Evans</u> | | 14. MOTHER'S MAIDEN NAME <u>Henretta</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident</u> DUE TO (b) <u>Generalized Art. Sclerosis</u> DUE TO (c) <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVA. BETWEEN ONSET AND DEATH <u>21 days</u> <u>30 yrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>Jack E Collins</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>Jack E Collins</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>9-4-60</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem.</u> |
| 22d. LOCATION (City, town, or county) <u>Anne Arundel Co., Md.</u> | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Randolph J. Collick</u> | | ADDRESS <u>1412 E. Preston St.</u> | |
| 24a. REC'D BY REGISTRAR <u>SEP 6 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u> | |

DATE SIGNED
8-31-60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| | | | |
|---|------------------------------|--|---------------------------------------|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission, a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL, and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 12Y, 8M, 1D | |
| d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Spring Grove State Hospital | | e. STREET ADDRESS MARYLAND HOUSE OF CORRECTION | |
| 3 NAME OF DECEASED (Type or print) William O. Evans | | 4. DATE OF DEATH August 7 1960 | |
| 5 SEX MALE | 6 COLOR OR RACE White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH July -11- 1881 |
| 9 AGE (In years last birthday) 79 yrs | | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mechanic | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | |
| 11 BIRTHPLACE (State or foreign country) Baltimore Maryland | | 12 CITIZEN OF WHAT COUNTRY? U. S. A | |
| 13 FATHER'S NAME George O. Evans | | 14 MOTHER'S MAIDEN NAME Elizabeth ? | |
| 15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16 SOCIAL SECURITY NO — | |
| 17 INFORMANT Spring Grove records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | |
| PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) WITH HYPERTENSION DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19 | | 20d INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21 I certify that (I) (this hospital) attended the deceased from June 22nd 1960. to Aug 7th 1960. that (I) (we) last saw the deceased alive on 19 and that death occurred at 3:05 PM , from the causes and on the date stated above. | | | |
| 22a SIGNATURE Patrick K. Yip | | 22b DATE SIGNED | |
| 22c PHYSICIAN'S NAME (Type) Patrick K. Yip, M.D. | | 22d ADDRESS SPRING GROVE STATE HOSPITAL BALTIMORE 28 MD. | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE THEREOF 8-10-60 | |
| 23c NAME OF CEMETERY OR CREMATORY Lincoln Cemetery | | 23d LOCATION (City, town or county) Baltimore (State) MD | |
| 24 FUNERAL DIRECTOR'S SIGNATURE James Colman | | 25a REC'D BY REGISTRAR DATE AUG 11 '60 | |
| 25b REGISTRAR'S SIGNATURE Arthur S. Kneass | | | |



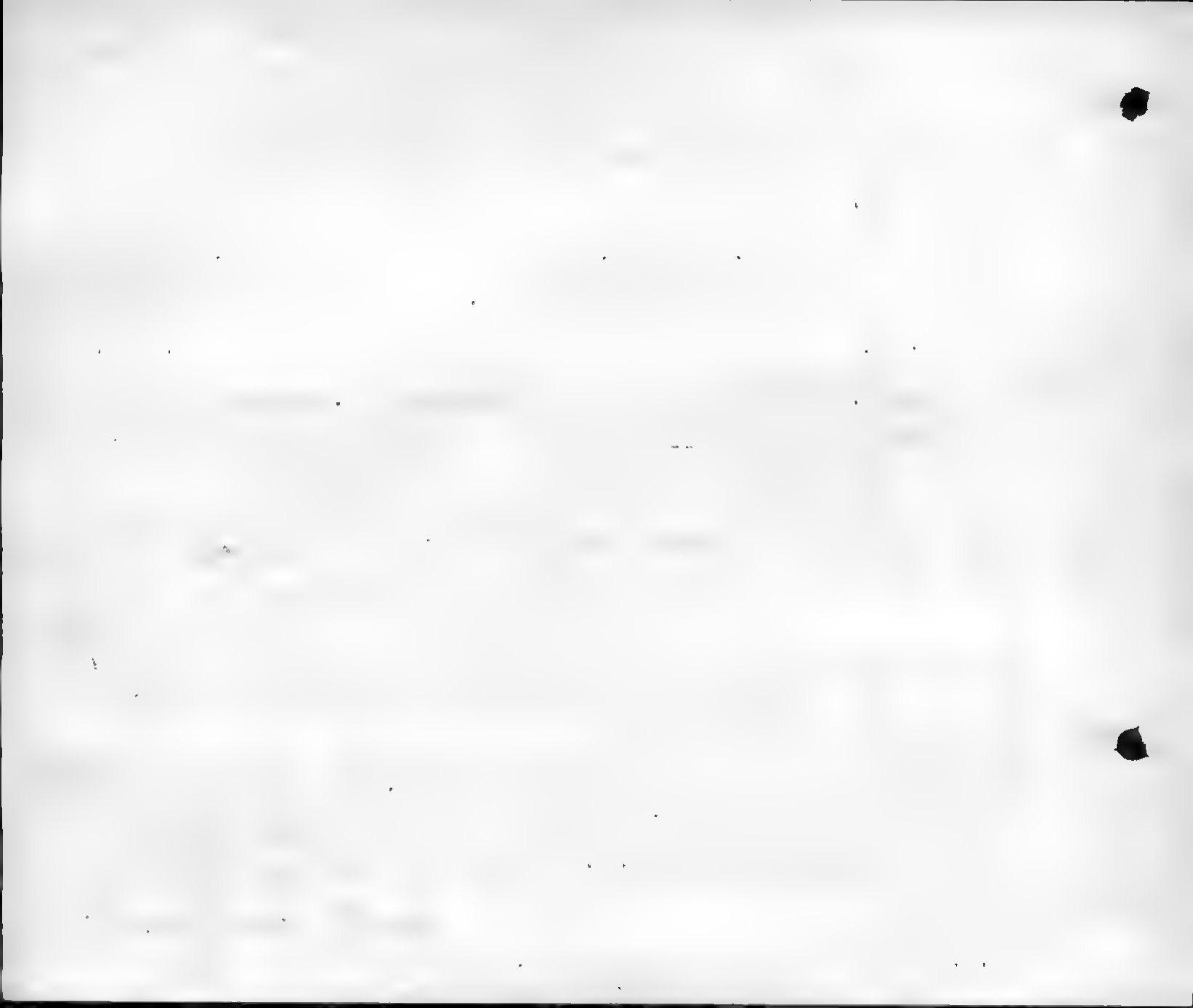
8845
CERTIFICATE OF DEATH

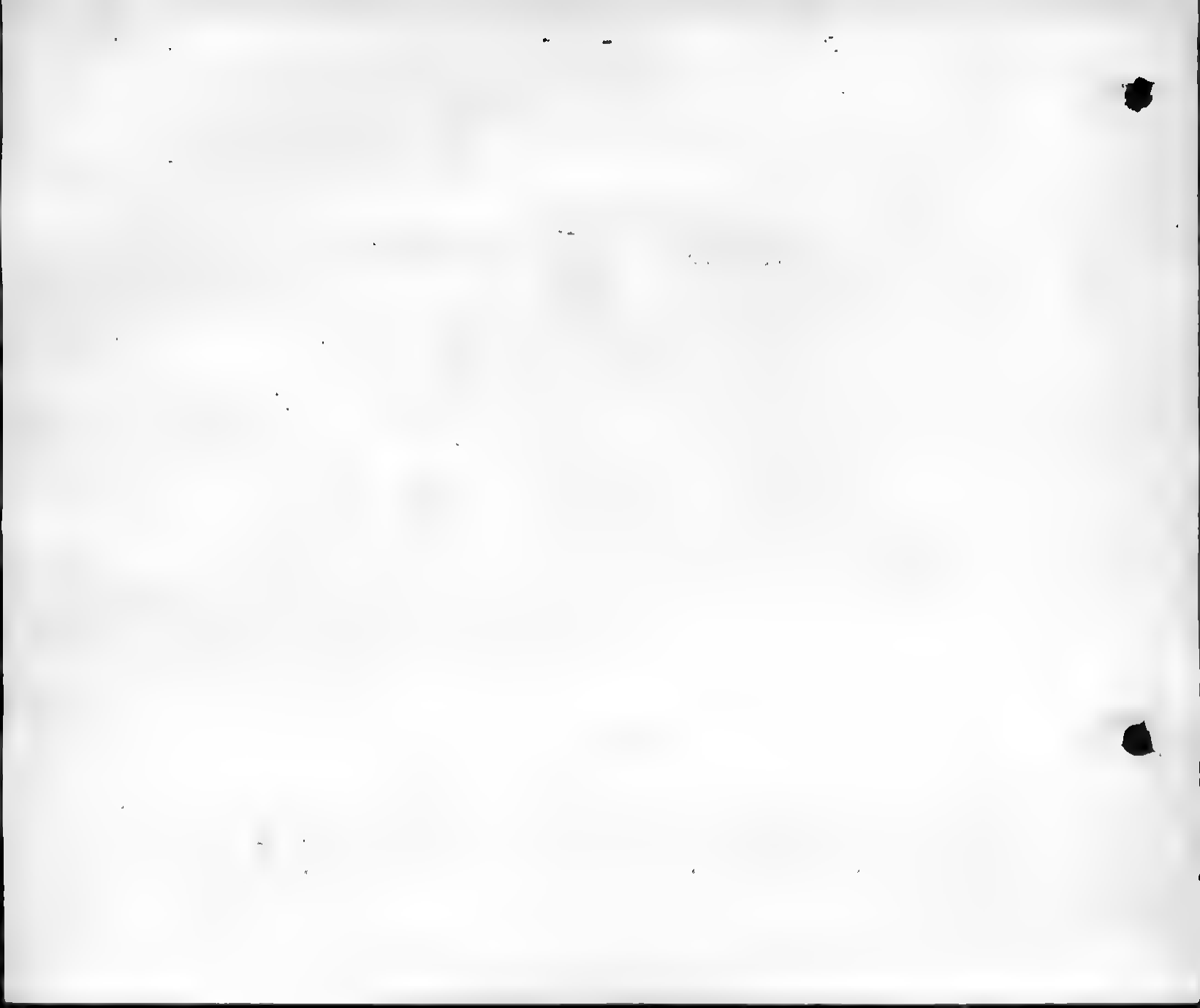
Reg. Dist. No.

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|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Charles</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 28</u> | | | | c. LENGTH OF STAY IN 1b <u>15 months</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House of the Pines</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bryantown</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>JANE CATHERINE FARRALL</u> | | | | 4. DATE OF DEATH Month Day Year <u>8 - 15 - 1960</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Feb 22, 1872</u> | |
| 9. AGE (In years last birthday) <u>88</u> yrs | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>UNK</u> | | | | 14. MOTHER'S MAIDEN NAME <u>UNK</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>NO</u> | | | | 16. SOCIAL SECURITY NO <u>NONE</u> | | 17. INFORMANT <u>R. Earl Farrall, Waldorf, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO SCLEROTIC CARDIO</u> <u>VASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DUE TO</u> (c) <u>10 YRS</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 YRS</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from <u>JANUARY 1950</u> to <u>5/10, 1960</u> , that I last saw the deceased alive on <u>8/14, 1960</u> , and that death occurred at <u>1:15</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Phyllis E. Knecht</u> | | | | ADDRESS (Street, city or town, state) <u>3624 E. Davidson Ave</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Thos E Roach</u> | | | | DATE SIGNED <u>8/15/60</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>8-18-60</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u> | | 22d. LOCATION (City, town or county) (State) <u>Bryantown Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>The HUNT Funeral Home, Waldorf, Md.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>AUG 19 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knecht</u> | |

THIS CERTIFICATE OF DEATH IS TO BE SIGNED BY THE ATTENDING PHYSICIAN. The law requires that the death certificate be completed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health for or to burial, cremation, or removal, and in any event, within 27 hours after death.

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15M 9-2-59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08818

| | | | |
|---|---------------------------------|---|---|
| 1. PLACE OF DEATH a COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a STATE Maryland b COUNTY Baltimore | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead - RFD | | c LENGTH OF STAY IN 1b | |
| d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d STREET ADDRESS | |
| e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3 NAME OF DECEASED (Type or print) First Tom Middle TWIN II Last Fowble | | 4 DATE OF DEATH Month August Day 23 Year 19 60 | |
| 5 SEX Male | 6 COLOR OR RACE White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH Aug. 23, 1960 |
| 9 AGE (In years last birthday) yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12 CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Pleasant Fowble | | 14. MOTHER'S MAIDEN NAME Evelyn Tipton | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO (If yes, give war or dates of service) | |
| 17. INFORMANT Pleasant Fowble, Hampstead, RFD, Maryland | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 min. | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f (City or town) (County) (State) | |
| 21 I certify that (I) (this hospital) attended the deceased from 8/23/ 19 60 to 8/20 19 60 , that (I) (we) last saw the deceased alive on 8/23/ 19 60 , and that death occurred at 12:45 PM from the causes and on the date stated above | | | |
| 22a SIGNATURE M. C. Porterfield | | 22b DATE SIGNED | |
| 22c PHYSICIAN'S NAME (Type) M. C. Porterfield | | 22d ADDRESS Hampstead, Maryland | |
| 23a BURIAL, CREMATION, OR REMOVAL (Specify) Burial | | 23b DATE THEREOF Aug. 23, 1960 | |
| 23c NAME OF CEMETERY OR CREMATORY Greenmount | | 23d LOCATION (City, town, or county) (State) Carroll Co., Md. | |
| 24 FUNERAL DIRECTOR'S SIGNATURE Edward C. Tipton, Hampstead, Md. | | 25a REC'D BY REGISTRAR DATE SEP 1 1960 | |
| 25b REGISTRAR'S SIGNATURE Wm. S. Thomas | | | |

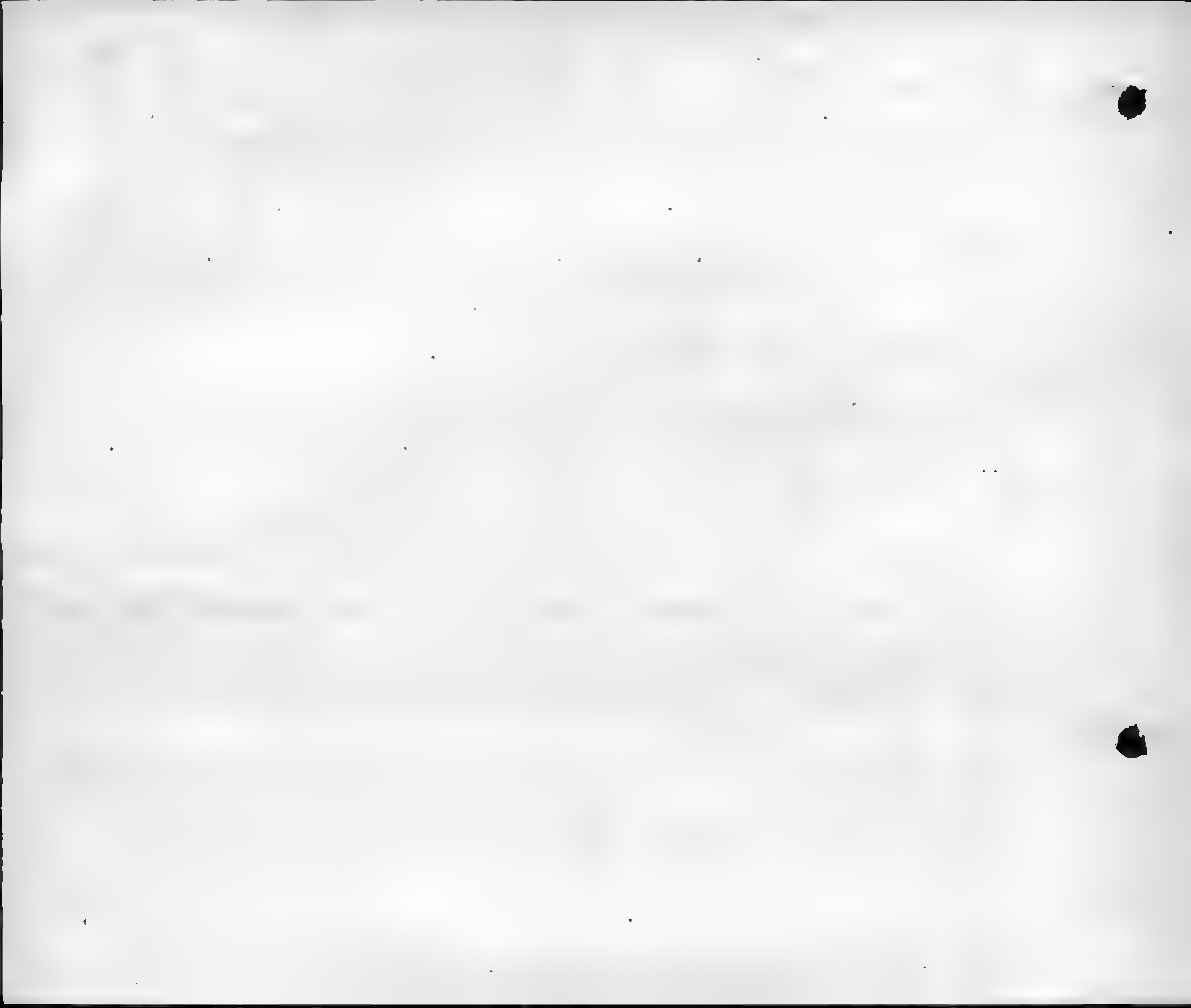


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8849
CERTIFICATE OF DEATH08819
Reg. Dist. No.

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Balto. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before adm is on) a. STATE Md. b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) English Consil | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) English Consil | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3612 Lilac Ave. | | d. STREET ADDRESS 3612 Lilac Ave. | |
| 3. NAME OF DECEASED (Type or print) William A. Frey, Sr. | | 4. DATE OF DEATH Month Aug. Day 19 Year 1960 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 10, 1876 |
| 9. AGE (In years last birthday) 83 yrs | | IF UNDER 1 YEAR Months Days Hours Min | IF UNDER 24 HRS Months Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Butcher | 11. BIRTHPLACE (State or foreign country) Md. |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Charles A. Frey | |
| 14. MOTHER'S MAIDEN NAME Hesther Dundee | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no | |
| 16. SOCIAL SECURITY NO 218-01-5598 | | 17. INFORMANT Address Mrs. Mary E. Frey-3612 Lilac Ave. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 13 hours | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Aug 19, 1960 to Aug 19, 1960 , that I last saw the deceased alive on Aug 19, 1960 , and that death occurred at 10:20 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE C. Arthur Rossberg M.D. | | ADDRESS (Street, city or town, state) 2436 Washington Rd. Baltimore 30 Maryland | |
| PHYSICIAN'S NAME (Type) C. ARTHUR ROSSBERG | | DATE SIGNED 8/22/60 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Aug. 23, 1960 | 22c. NAME OF CEMETERY OR CREMATORY St. John's | 22d. LOCATION (City, town, or county) (State) Ellicott City Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE John T. Stansbury-6411 Windsor Mill Rd. | | 24a. REC'D BY REGISTRAR DATE AUG 23 '60 | |
| 24b. REGISTRAR'S SIGNATURE C. H. S. Frank | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

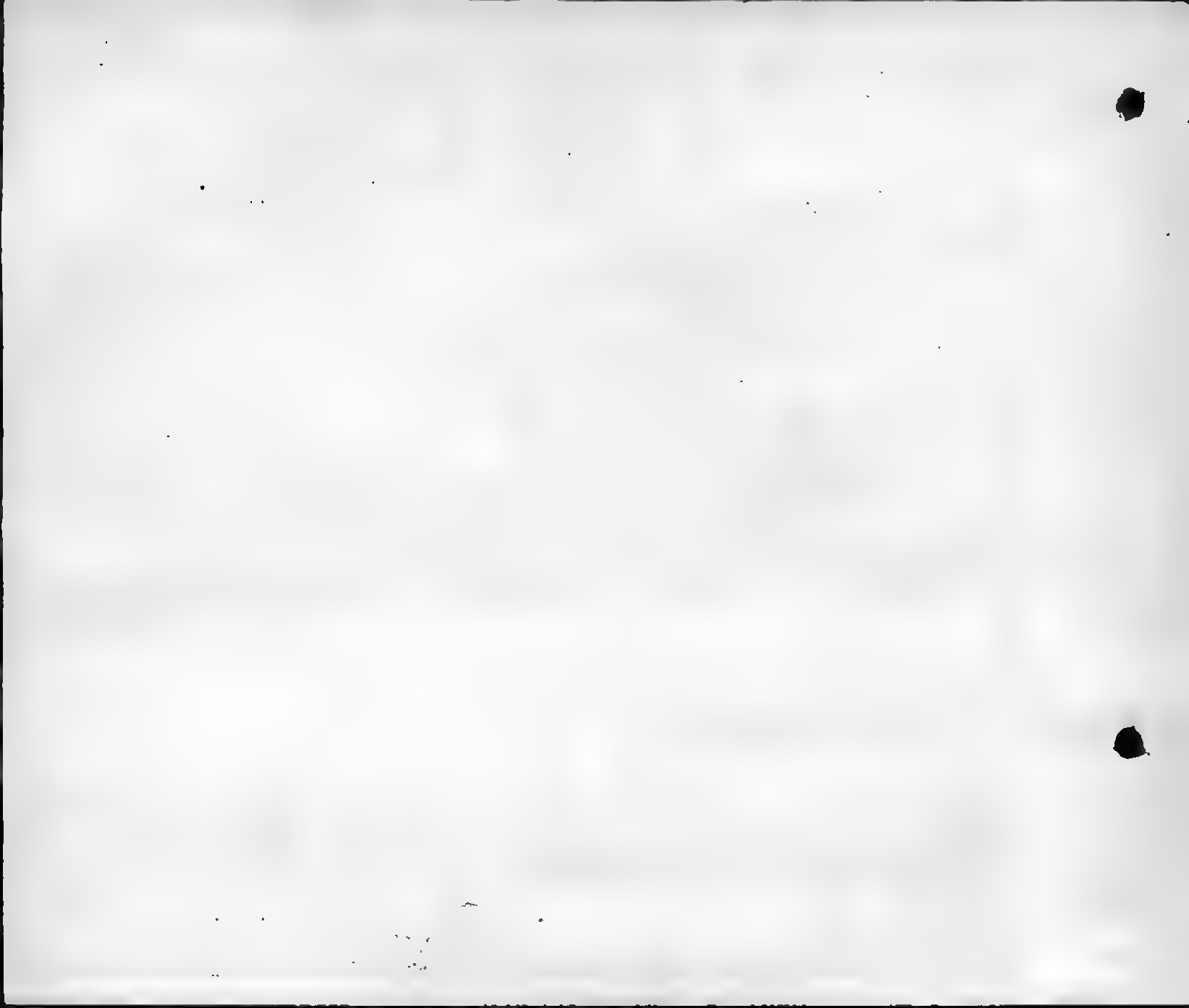
08820

Reg. Dist. No.

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3610 LANDBECK RD</u> | | d. STREET ADDRESS <u>3610 Landbeck Rd.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>MARIE LOUISE GILES</u> | | 4. DATE OF DEATH Month <u>8</u> Day <u>13</u> Year <u>1960</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/13/1899</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School teacher</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>School teacher</u> | 9. AGE (In years last birthday) <u>61</u> yrs. |
| 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Edward Giles</u> | | 14. MOTHER'S MAIDEN NAME <u>Emma Overmyer</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>214-40-4863</u> | |
| 17. INFORMANT <u>M.R. CARD</u> | | Address <u>3610 LANDBECK RD</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>175.0</u> DUE TO <u>symptoms of coronary arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Emotion</u> DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH <u>18 months</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) _____ (County) _____ (State) _____ |
| 21. I certify that I attended the deceased from <u>April 13, 1959</u> to <u>April 13, 1960</u> , that I last saw the deceased alive on <u>April 13, 1960</u> , and that death occurred at <u>10:50 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Edwin L. Pilgrimage</u> M.D. <u>82-041-5147</u> | | DATE SIGNED <u>10/13/60</u> | |
| PHYSICIAN'S NAME (Type) <u>EDWIN L. PILGRIMAGE</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>8/15/60</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u> | 22d. LOCATION (City, town, or county) <u>Woodlawn, Md.</u> (State) _____ |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Vickers & Sons - Balt</u> | | 24a. REC'D BY REGISTRAR <u>DATE AUG 5 '60</u> | 24b. REGISTRAR'S SIGNATURE <u>Wm. J. Vickers</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

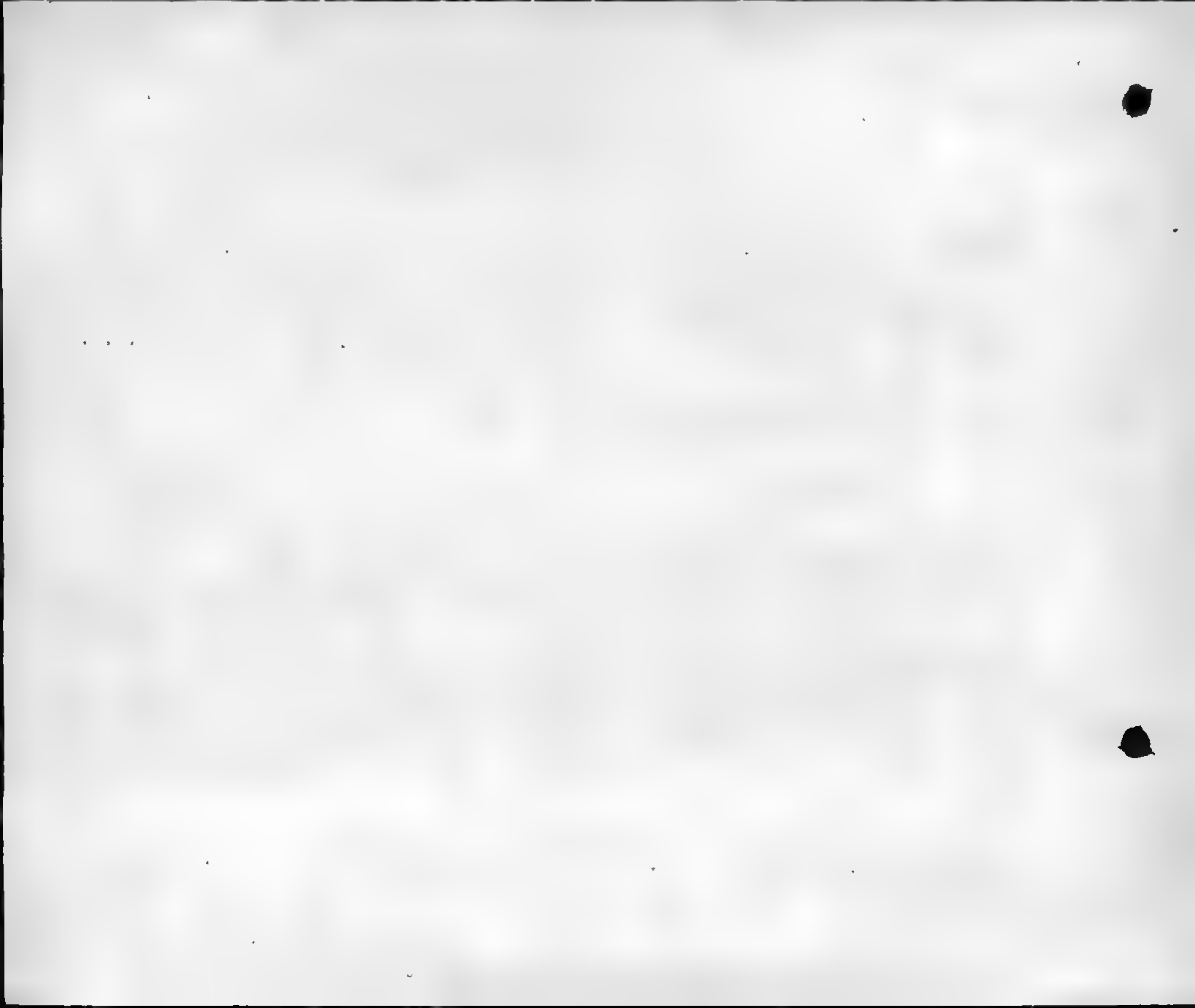
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8851

Reg. Dist. No. 08821

| | | | | | | | | | | | | | | | | | | | |
|---|--|-----------------------------|---------------------------------|---|--|--|--|---|--|--|--|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u> | | | | | | | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> | | | c. LENGTH OF STAY IN 1b | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> <u>52</u> | | | | | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>121 Winters Ave.</u> | | | | d. STREET ADDRESS <u>121 Winters</u> <u>1</u> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Dorothy Ann</u> Middle <u>Hill</u> Last <u></u> | | | | 4. DATE OF DEATH Month <u>Aug.</u> Day <u>27</u> Year <u>1960</u> | | | | | | | | | | | | | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>Col</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>July 12, 1892</u> | | 9. AGE (In years last birthday) <u>68</u> yrs. | | IF UNDER 1 YEAR Months <u></u> Days <u></u> | | IF UNDER 24 HRS. Hours <u></u> Min. <u></u> | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | | | 11. BIRTHPLACE (State or foreign country) <u>MD</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Larson</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Ellen Bailey</u> | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>212-67-7478</u> | | | | 17. INFORMANT <u>John Hill</u> Address <u>121 Winters Ave.</u> | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardio vasculæheart disca</u> DUE TO (c) <u></u> | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u></u> | | | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u>19</u> p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) | | (County) | | (State) | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Geo. M. Kieffer</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED <u>Aug. 27, 1960</u> | | | | | | | | | | | |
| EXAMINER'S NAME (Type) <u>Geo. M. Kieffer</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 22b. DATE THEREOF <u>8-31-60</u> | | | | 22c. NAME OF CEMETERY OR CREMATORY <u>Mount Auburn</u> | | | | 22d. LOCATION (City, town, or county) (State) <u>BALTIMORE</u> <u>MD</u> | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>MRS JESSIE A. Lively</u> | | | | | | ADDRESS <u>6614 BARRE ST</u> | | | | | | 24a. REC'D BY REGISTRAR <u>DATE AUG 30 '60</u> | | | | 24b. REGISTRAR'S SIGNATURE <u>Charles S. Harris</u> | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08822

Reg. Dist. No.

8796

| | | | | | | | |
|---|------------------------------|---|---|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balt Highlands</u> | | c. LENGTH OF STAY IN TB | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balt Highlands</u> | | d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2908 Keelamar Ave</u> | | | | d. STREET ADDRESS <u>2908 Keelamar Ave</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Pauline</u> Middle <u>Ginter</u> Last <u>Ginter</u> | | | | 4. DATE OF DEATH Month <u>Aug</u> Day <u>18</u> Year <u>1960</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept 15 1877</u> | | 9. AGE (in years last birthday) <u>82</u> yrs. | IF UNDER 1 YEAR Months <u></u> Days <u></u> | IF UNDER 24 HRS. Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Poland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Henry Ginter</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Jennie Knop</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u></u> | | 17. INFORMANT <u>Family</u> Address <u>same</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart disease</u> DUE TO (b) <u>Cardiovascular heart disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <u></u> DUE TO (c) <u></u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u></u> p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Ger. S. M. Kieffer</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>GER. S. M. KIEFFER M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u> | | 22b. DATE THEREOF <u>8-22-60</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Cath. in Baltimore</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kieffer</u> | | | | ADDRESS <u>130 E. Fayette</u> | | 24a. REC'D BY REGISTRAR DATE <u>AUG 22 '60</u> | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kieffer</u> | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



**THIS IS A PERMANENT RECORD.
ALL INFORMATION SHOULD BE CAREFULLY SUPPLIED.
WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY.**

| | | | |
|--|---------------------------|--|--------------------------------|
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE OF DEATH | |
| William H Granger | | Aug 11/1960 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If no tuition; residence before admission) | |
| Baltimore County (If not in hospital or institution, give street address or location) 6816 Campfield Road | | A. STATE Maryland B. CITY OR TOWN Rural Lochearn C. STREET ADDRESS 6816 Campfield Road | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widower | 8. DATE OF BIRTH Jan 2/1880 |
| 9. AGE (In years last birthday) 80 | | 10. CITIZEN OF WHAT COUNTRY? Under 1 Year Months Days Hours Min | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst Supt Mail Ret | | 10B. KIND OF BUSINESS OR INDUSTRY US Post office | |
| 11. BIRTHPLACE (State or foreign country) Baltimore Md. | | 12. CITIZEN OF WHAT COUNTRY? Under 1 Year Months Days Hours Min | |
| 13. FATHER'S NAME Joseph Granger | | 14. MOTHER'S MAIDEN NAME Rosa Mason | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO | |
| | | 17. INFORMANT Hertell Granger 6816 Campfield Road | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST | | 19. CAUSE OF DEATH (A) Coronary thrombosis DUE TO (B) Cardio-vascular disease DUE TO advanced atherosclerosis (C) | |
| 20. INTERVAL BETWEEN ONSET AND DEATH about 2 hrs. | | 21. INTERVAL BETWEEN ONSET AND DEATH about 5 yrs | |
| 22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | | |
| 23. IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II | | 24. DATE OF OPERATION Jan 1955 | |
| 25. 19A. DATE OF OPERATION Jan 1955 | | 26. 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED WORK [] AT WORK [] | |
| 27. 20. AUTOPSY? YES [] NO [X] | | | |
| 28. I certify that (I) (this hospital) attended the deceased from Aug 11 1960 to Aug 11 1960, that (I) (we) last saw the deceased alive on July 31 1960, and that in (my) (our) opinion death occurred at 9:40 a.m., from the causes and on the date stated above. | | | |
| 29. 23A. SIGNATURE Hertell S. Niblett ATTENDING PHYS. [] MED. DIRECTOR [] STAFF PHYS. [] M.D. | | 30. 23B. ADDRESS 1501 Pentridge Rd | |
| 31. 23C. DATE SIGNED Aug 11/60 | | | |
| 32. 24A. BURIAL, CREMATION, REMOVAL (Specify) Entombment | | 33. 24B. DATE Aug 15/1960 | |
| 34. 24C. NAME OF CEMETERY OR CREMATORY Lorraine | | 35. 24D. LOCATION (City town or county) (State) Goodlawn Md | |
| 36. 25A. DATE REC'D BY HOSP AUG 12 1960 | | 37. 25B. NAME OF REGISTRAR Huntington Williams, N.Y. | |
| 38. 25C. FUNERAL DIRECTOR Harry A. Armbrust | | 39. ADDRESS 4204 Ridgebrook | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8853

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08824

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 28 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

| | | | | | |
|---|---|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River #20</u> | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River #20</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>321 Grovethorn Road</u> | | | d. STREET ADDRESS <u>321 Grovethorn Road</u> | | |
| 3. NAME OF DECEASED (Type or print) <u>John L. Greenlee</u> | | | 4. DATE OF DEATH Month <u>August</u> Day <u>4</u> Year <u>1960</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 18, 1906</u> | | 9. AGE (in years last birthday) <u>54</u> yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Aircraft</u> | | 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>Samuel B. Greenlee</u> | | | 14. MOTHER'S MAIDEN NAME <u>Caroline Simpson</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> | | 16. SOCIAL SECURITY NO. <u>400-09-4657</u> | | 17. INFORMANT <u>Mary Greenlee</u> Address <u>Same</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>20.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE <u>Jack C Collins</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED <u>8-6-60</u> | |
| EXAMINER'S NAME (Type) <u>JACK C Collins</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>8/8/60</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Balto. National Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>James Brudinski</u> | | ADDRESS <u>1407 Eastern Ave.</u> | | 24a. REC'D BY REGISTRAR DATE <u>AUG 9 '60</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |



Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

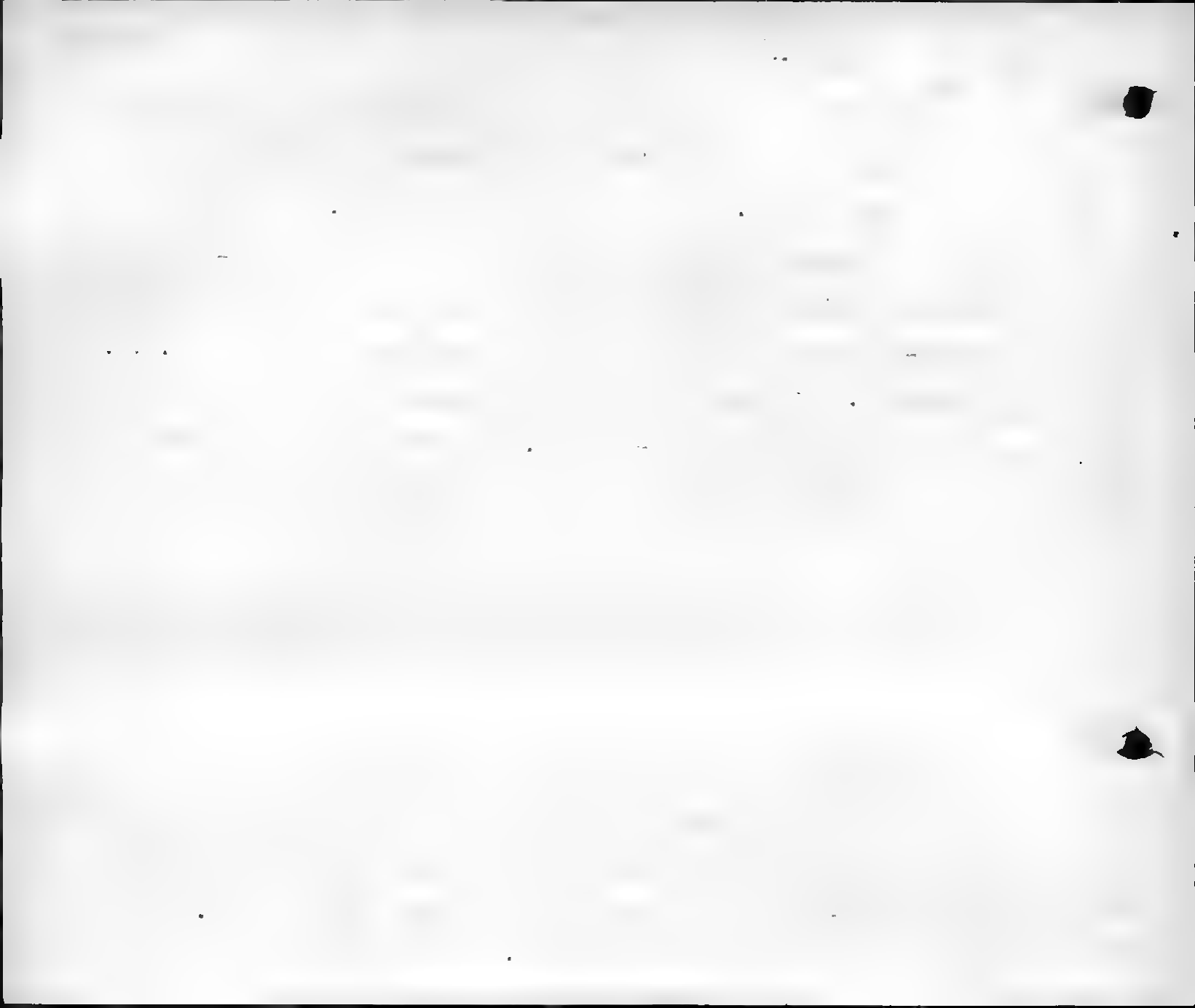
8854

CERTIFICATE OF DEATH

Reg. Dist. No.

08825

| | | | |
|--|----------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phoenix | | c. LENGTH OF STAY IN 1b life | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stockton Rd. | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phoenix | |
| f. STREET ADDRESS Stockton Rd. | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Thomas Taylor Griffith IV | | 4. DATE OF DEATH Month Day Year 8-4-60 19 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11-16-1891 |
| 9. AGE (in years last birthday) 68 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) owner-operator | | 10b. KIND OF BUSINESS OR INDUSTRY farm | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Thomas T. Griffith | | 14. MOTHER'S MAIDEN NAME Louisa Holland | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 219-30-8113 | |
| 17. INFORMANT R. Lloyd Smith | | Address above | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Cardio Vascular disease DUE TO 4-2-2-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 4 yrs - | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 8-3 , 19 60 , to 8-4 , 19 60 ; that I last saw the deceased alive on 8-4 , 19 60 , and that death occurred at 9:30 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE C. Herbert Mueller Jr. M.D. | | ADDRESS (Street, city or town, state) York Rd., Hanford, Md. DATE SIGNED 8-5-60 | |
| PHYSICIAN'S NAME (Type) C. HERBERT MUELLER Jr. | | PARKTON P.O. MD | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8-8-60 | |
| 22c. NAME OF CEMETERY OR CREMATORY Clymmlira Methodist | | 22d. LOCATION (City, town, or county) (State) Monkton, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md. | | 24a. REC'D BY REGISTRAR DATE AUG 10 '60 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | |



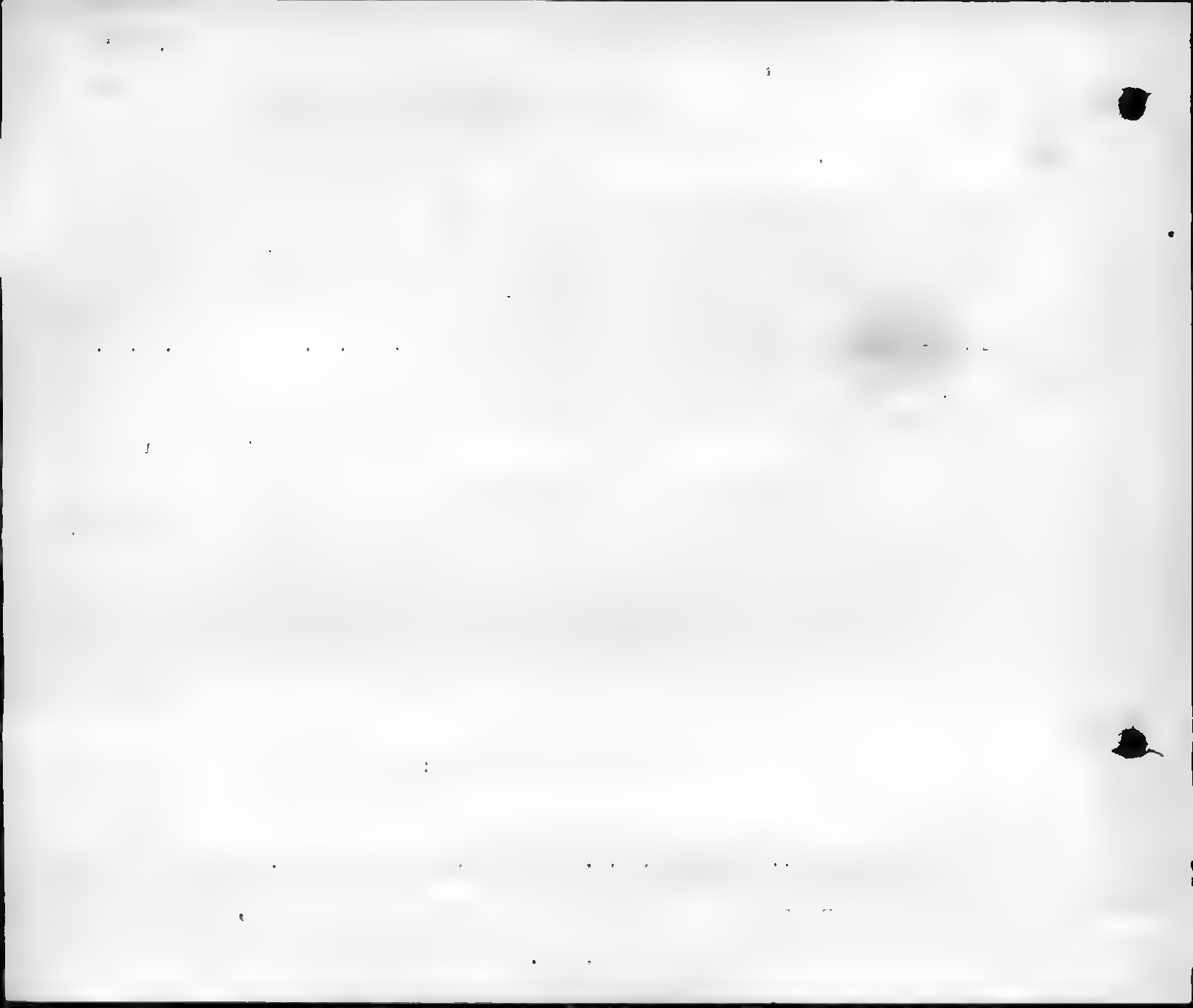
Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8855

08826

| | | | | | | |
|--|----------------------------------|---|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard, Md. c. LENGTH OF STAY IN 1b 118 Days d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore City d. STREET ADDRESS 1916 Mount Royal Terrace (17) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) First JAMES Middle Elwood Last GRIMSLEY | | 4. DATE OF DEATH Month August Day 17 Year 1960 | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH December 27, 1891 | 9. AGE (In years, last birthday) 68 yrs | 10. IF UNDER 1 YEAR Months 0 Days 0 | 11. IF UNDER 24 HRS Hours 0 Min 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk - Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Real Estate Board | | 11. BIRTHPLACE (State or foreign country) Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
| 13. FATHER'S NAME Patrick Grimsley | | 14. MOTHER'S MAIDEN NAME Lorena Groves | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes WW I | | 16. SOCIAL SECURITY NO. Card lost | | 17. INFORMANT Address Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Unknown (c) Unknown PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebrovascular Accident - Left Middle Cerebral Artery, Right Hemiparesis INTERVAL BETWEEN ONSET AND DEATH 48 Hours | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that (X) (this hospital) attended the deceased from April 21, 1960 , to August 17, 1960 , that (X) (we) last saw the deceased alive on August 17, 1960 , and that death occurred at 6:15 A. M. from the causes and on the date stated above | | | | | | |
| 22a. SIGNATURE FREDERICK S. DONALDSON, M.D. | | 22b. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D. | | 22c. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION | | 22d. DATE 8/17/60 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8-20-60 | | 23c. NAME OF CEMETERY OR CREMATORY Blue Ridge Cemetery | | 23d. LOCATION (City, town, or county) (State) Thurmont, Maryland |
| 24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Braggs | | 24b. ADDRESS Thurmont, Md. | | 25a. REC'D BY REGISTRAR DATE AUG 23 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kline |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8858

CERTIFICATE OF DEATH

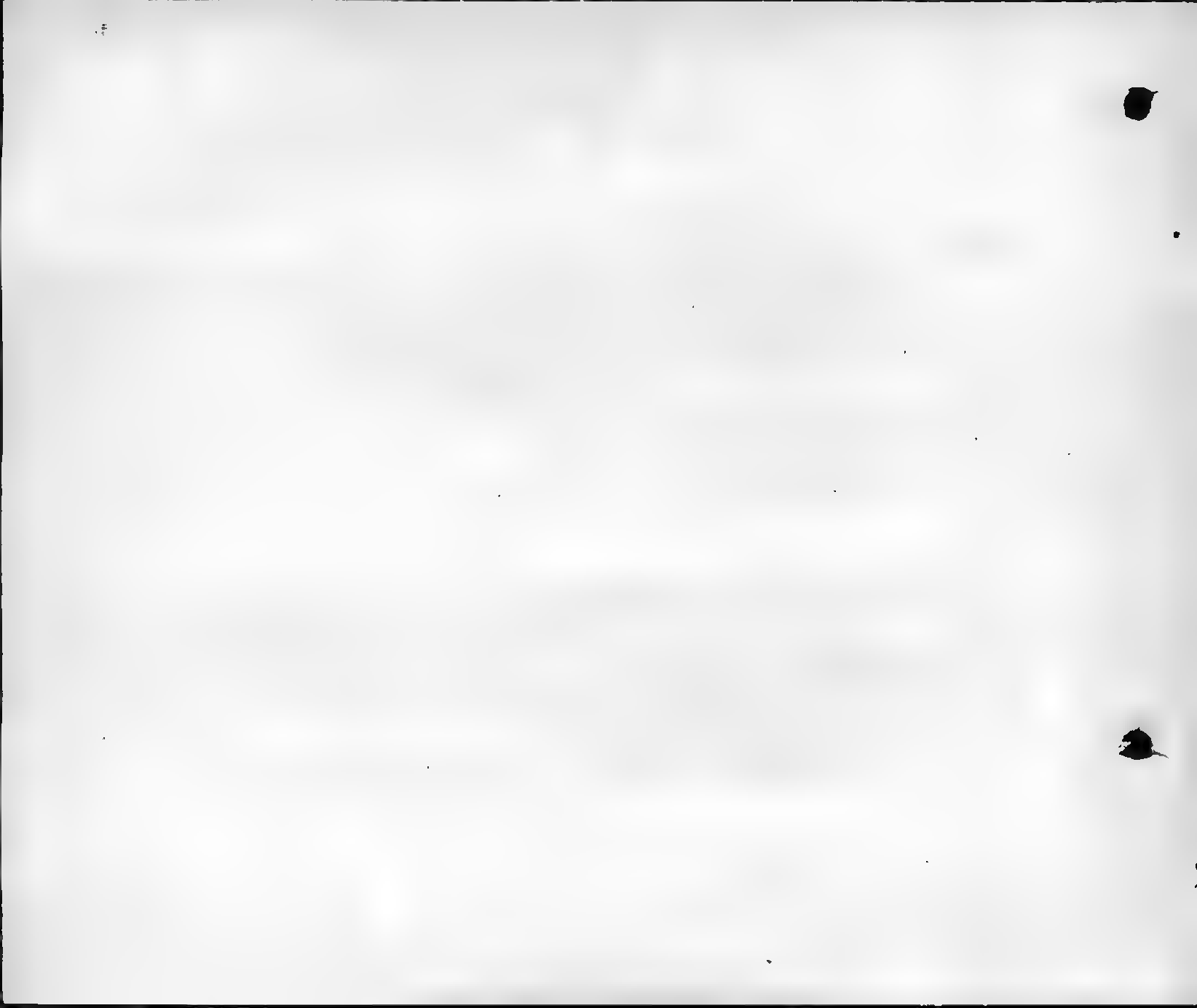
08827

Reg. Dist. No.

| | | | |
|---|---------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u> | | c. LENGTH OF STAY IN 1b <u>4 YRS.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4124 Baker Lane</u> | | e. STREET ADDRESS <u>14124 Baker Lane</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>C.</u> Last <u>Halpin</u> | | 4. DATE OF DEATH Month <u>Aug</u> Day <u>27</u> Year <u>1960</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 18 1867</u> |
| 9. AGE (In years, last birthday) <u>93</u> yrs | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Balto, Co MD</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Joseph Snyder</u> | | 14. MOTHER'S MAIDEN NAME <u>Ann Waters</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>215-01-50770</u> | |
| 17. INFORMANT <u>Catherine R. Kendall</u> | | Address <u>4124 Baker Lane</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO <u>Unlignent Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Cardiac Failure</u> (b) <u>Cardiac Failure</u> (c) <u>Cardiac Failure</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o m p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>8/20</u> , 19 <u>60</u> , to <u>8/27</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>8/26</u> , 19 <u>60</u> , and that death occurred at <u>1:30</u> P.M. from the causes and on the date stated above | | | |
| ACTUAL SIGNATURE <u>Fred Ruzic</u> M.D. | | ADDRESS (Street, city or town, state) <u>1011 N Charles St</u> DATE SIGNED | |
| PHYSICIAN'S NAME (Type) <u>FRED Ruzic MD</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>AUG 30 1960</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL CEM.</u> | | 22d. LOCATION (City, town, or county) (State) <u>FREDERICK RD MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>DIPPEL BROS</u> ADDRESS <u>7110 BELAIR RD</u> | | 24a. REC'D BY REGISTRAR <u>AUG 29 '60</u> DATE | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: All of this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

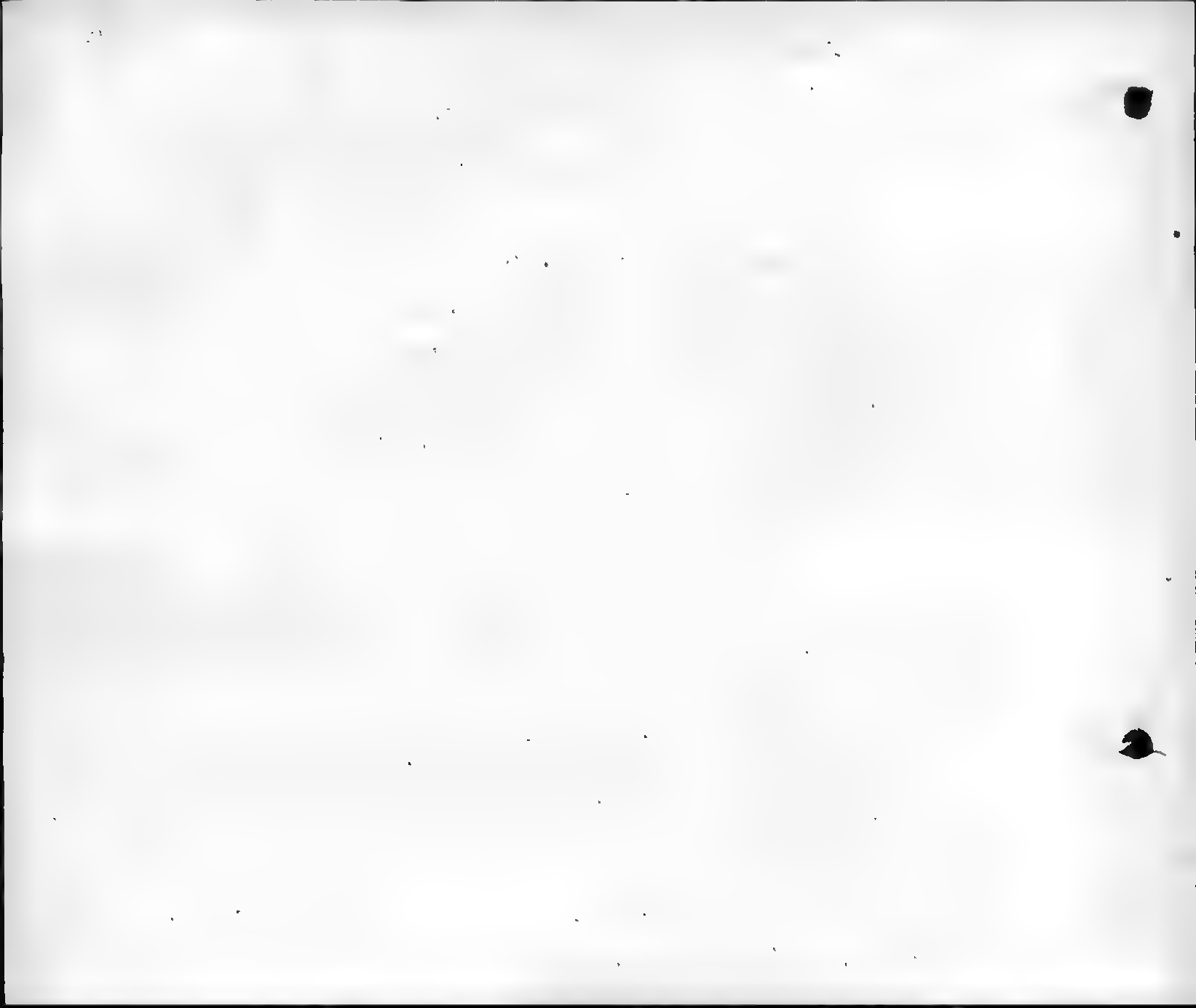
VS A15 (4)
15M 9/58

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 8857 CERTIFICATE OF DEATH

08825

Reg. Dist. No.

| | | | |
|---|-------------------------------|---|-----------------------------------|
| 1 PLACE OF DEATH a. COUNTY <i>Baltimore</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Parkville</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <i>8003 Jacqueline Lane</i> | | 2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Parkville</i> d. STREET ADDRESS <i>8003 Jacqueline Lane</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <i>Joseph</i> Middle <i>John</i> Last <i>Hartmann</i> | | 4. DATE OF DEATH Month <i>Aug.</i> Day <i>29</i> Year <i>19 60</i> | |
| 5. SEX <i>male</i> | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>8-27-1882</i> |
| 9. AGE (In years last birthday) <i>78</i> yrs | | 10. UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ice business</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Adam G. Hartmann</i> | | 14. MOTHER'S MAIDEN NAME <i>Theresa Justice</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO | |
| INFORMANT <i>Luella M. Hartmann</i> | | Address <i>same</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>Aug 7/60</i> to <i>Aug 29/60</i> , that I last saw the deceased alive on <i>Aug 29/60</i> , 19 <i>8:15 PM</i> , and that death occurred at <i>Md.</i> from the causes and on the date stated above ADDRESS (Street, city or town, state) <i>1924 W 12th</i> DATE SIGNED <i>8/30/60</i> | | | |
| ACTUAL SIGNATURE <i>Henry C. Hancock</i> M.D. | | PHYSICIAN'S NAME (Type) <i>Henry C. Hancock</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i> | | 22b. DATE THEREOF <i>9-3-60</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i> | | 22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> | | ADDRESS <i>5305 Harford Rd.</i> | |
| 24a. REC'D BY REGISTRAR <i>AUG 31 60</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur L. Francis</i> | |



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8858

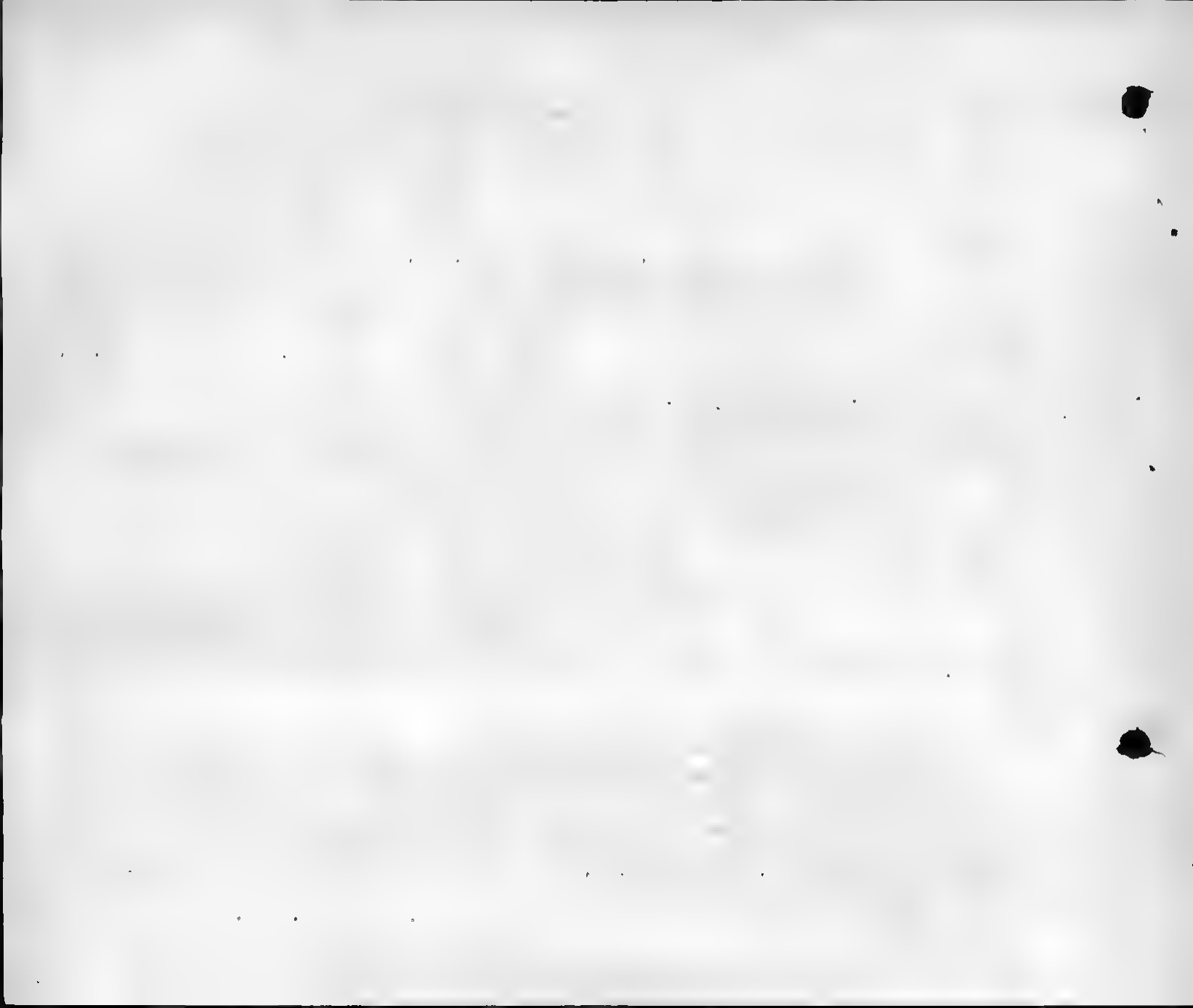
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08829

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|--|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | | |
| c. LENGTH OF STAY IN 1b 10yr5mth5dys | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL | | | | d. STREET ADDRESS 3608 Rosedale Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First James Middle R. Last Henderson, Jr. | | | | 4. DATE OF DEATH Month August Day 14 Year 19 60 | | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 24, 1923 | | 9. AGE (In years last birthday) 36 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland S. C. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME James R. Henderson, Sr. | | | | 14. MOTHER'S MAIDEN NAME Florence Ellis | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 163-05-9369 | | 17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Status convulsivus DUE TO Cerebral and dural adhesions Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Transfrontal Lobotomy DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUT NG TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour 3:00 p.m. 8-14 19 60 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital | | 20f. (City or town) (County) (State) Catonsville 28, Maryland | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <i>George M. Kieffer</i> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) George M. Kieffer, M. D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/17/60 | | 22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem. | | 22d. LOCATION (City, town, or county) (State) Balto., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm J. Schumacher, Jr.</i> | | | | ADDRESS <i>110 Pa. Ave. 12</i> | | 24a. REC'D BY REGISTRAR DATE AUG 16 '60 | |
| | | | | 24b. REGISTRAR'S SIGNATURE <i>C. E. Hanna</i> | | | |

DATE SIGNED
8-15-60



88599
CERTIFICATE OF DEATH

Reg. Dist No. 08830

| | | | |
|--|---------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Parkton</u> | | 2. USUAL RESIDENCE (Where deceased lived If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| c. LENGTH OF STAY IN 1b <u>27 yrs.</u> | | d. STREET ADDRESS <u>Mt. Carmel Rd. 1</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>A.</u> Middle <u>Virginia</u> Last <u>Herbert</u> | | 4. DATE OF DEATH Month <u>August</u> Day <u>24</u> Year <u>1960</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov 17, 1932</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Parkton, Md. R.D.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Scott Mays</u> | | 14. MOTHER'S MAIDEN NAME <u>Anna Bruehl</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Informant</u> | |
| 17. ADDRESS <u>John M. Herbert, Parkton, Md. R.D.</u> | | | |

| | | |
|--|--|----------------------------------|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma - generalized</u> 199-2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH |
|--|--|----------------------------------|

| | | |
|--|--|--|
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
|--|--|--|

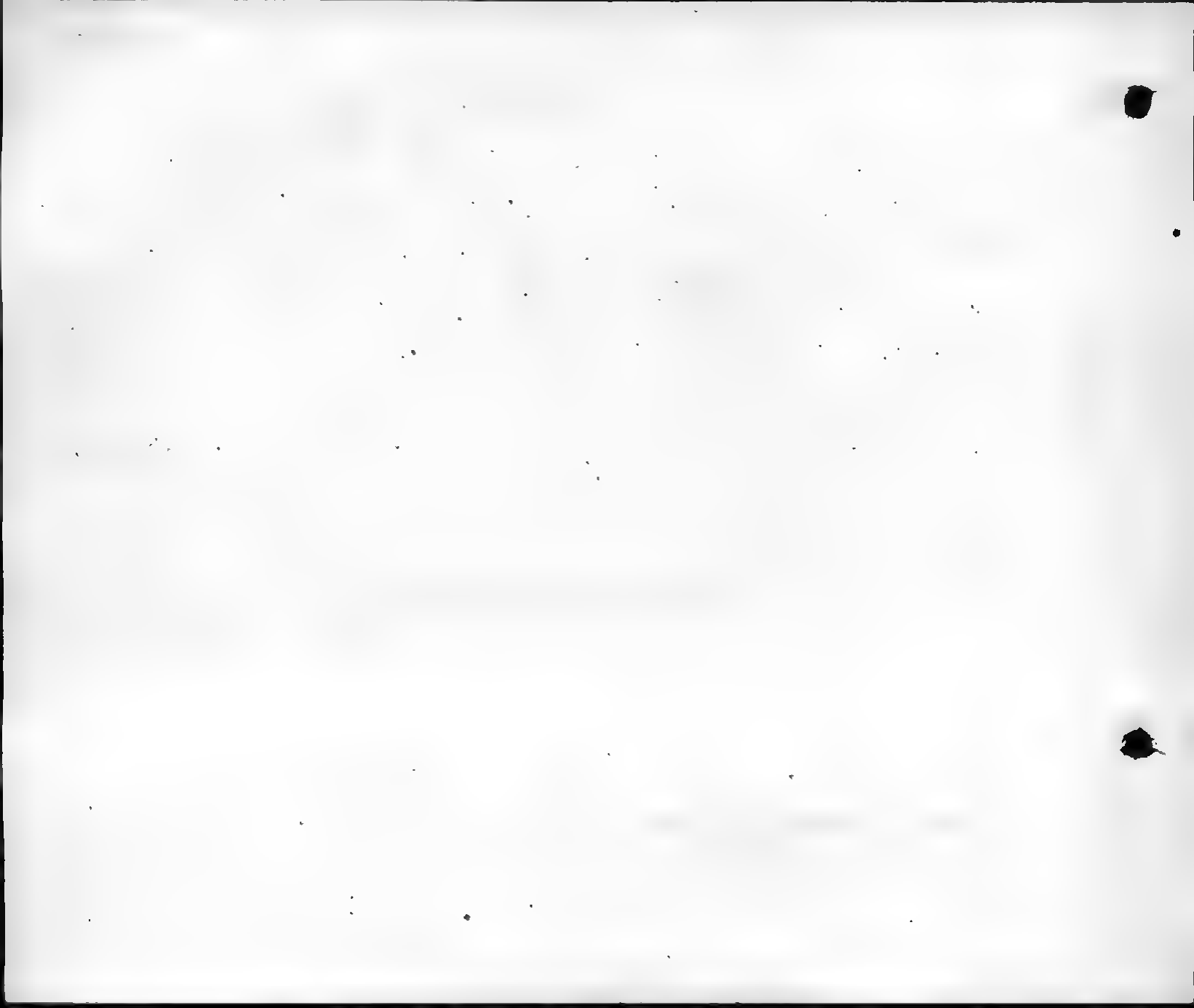
| | |
|--|--|
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |

21. I certify that I attended the deceased from April, 1960, to August 24, 1960, that I last saw the deceased alive on August 24, 1960, and that death occurred at 1:45 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE E. Herbert Mueller M.D. Shepherd - Parkton, P.O. box 8/25/60
DATE SIGNED
PHYSICIAN'S NAME (Type) E. HERBERT MUELLER, Jr.

| | | | |
|---|-------------------------|------------------------------------|---|
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| <u>Burial</u> | <u>Aug 27, 1960</u> | <u>Stablersville Cem.</u> | <u>Parkton, Md. R.D.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE | ADDRESS | 24a. REC'D BY REGISTRAR | 24b. REGISTRAR'S SIGNATURE |
| <u>David Hartenstein</u> | <u>New Freedom, Pa.</u> | DATE <u>AUG 29 '60</u> | <u>Carl A. Kone</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8860

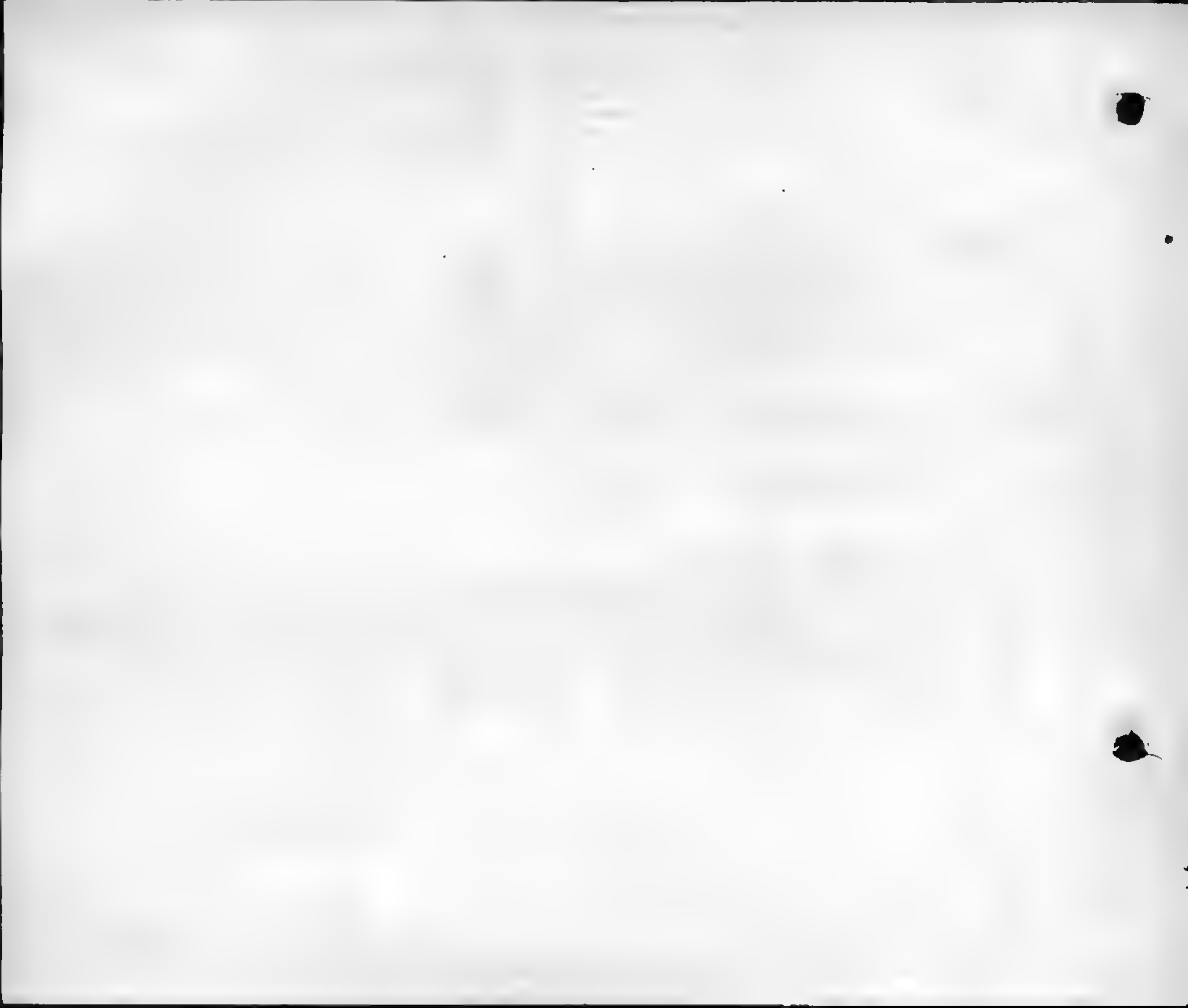
CERTIFICATE OF DEATH

08831

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton</u> | | c. LENGTH OF STAY IN TB <u>4 years</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Old York Road</u> | | | | d. STREET ADDRESS <u>Old York Road</u> | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Edmond Wheeler Holmes</u> | | | | 4. DATE OF DEATH Month <u>August</u> Day <u>26</u> Year <u>1960</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>17 March 1882</u> | 9. AGE (In years last birthday) <u>78</u> yrs | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HRS Hours _____ Min _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> | | 11. BIRTHPLACE (State or foreign country) <u>Hambrintown, Pa.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13. FATHER'S NAME <u>Daniel Holmes</u> | | | | 14. MOTHER'S MARDEN NAME <u>Maggie M. C. Coy</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>214-20-4002</u> | | 17. INFORMANT <u>Wife - Mary Jane</u> | | Address <u>Same</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A. S. C. U. D.</u> DUE TO . Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>7 years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month _____ Day _____ Year _____ Hour _____ a. m. _____ p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from <u>July 1960</u> to <u>Aug 1960</u> , that I last saw the deceased alive on <u>25 August 1960</u> , and that death occurred at <u>4:10</u> M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Walter T. Kees</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Cockeysville 26 August 60</u> DATE SIGNED | | | |
| PHYSICIAN'S NAME (Type) <u>WALTER T. KEES</u> | | | | <u>Maryland</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>8/29/60</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Middletown Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Free Land, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Fortenstein</u> | | | | ADDRESS <u>New Freedom, Pa.</u> | | 24a. REC'D BY REGISTRAR DATE <u>AUG 31</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Walter T. Kees</u> | | | |

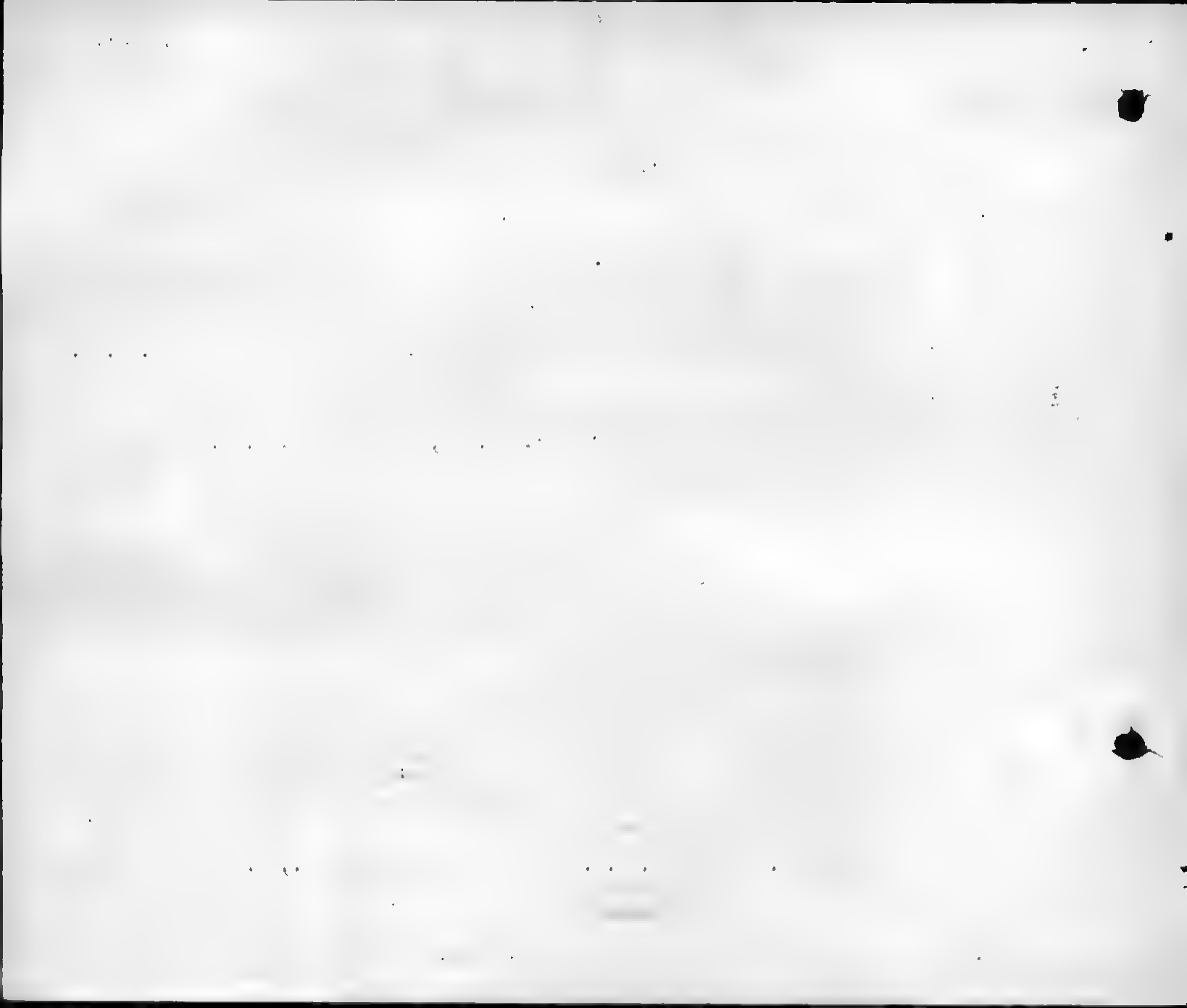
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event with in 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8861 CERTIFICATE OF DEATH 08832

| | | | | | | | |
|---|----------------------------------|---|---|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | | | c. LENGTH OF STAY IN 1b 28 DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn | | | |
| | | | | f. STREET ADDRESS (Box 22) | | | |
| 3. NAME OF DECEASED (Type or print) First FERRIS Middle E. Last HOOD | | | | 4. DATE OF DEATH Month August Day 14 Year 1960 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 4, 1896 | 9. AGE (In years last birthday) 64 yrs | 10. IF UNDER 1 YEAR Months Days | | 11. IF UNDER 24 HRS Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver | | 10b. KIND OF BUSINESS OR INDUSTRY Trucking | | 11. BIRTHPLACE (State or foreign country) Severn, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME John Hood | | | | 14. MOTHER'S MAIDEN NAME Rosetta Lowman | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war or dates of service) WW I | | 16. SOCIAL SECURITY NO 219-16-0963 | | 17. INFORMANT Clin. Rec. VAH, Baltimore 18, Md. Ft. Howard Division | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HEART FAILURE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (X) (this hospital) attended the deceased from July 17, 1960 to August 14, 1960 , that (X) (we) last saw the deceased alive on August 14, 1960 , and that death occurred on August 14, 1960 from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE FREDERICK S. DONALDSON, M.D. | | | | 22b. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION | | 22c. DATE 8/15/60 | |
| 23a. RURAL CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8-18-60 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery | | 23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc. | | | | 25a. REC'D BY REGISTRAR AUG 24 60 | | 25b. REGISTRAR'S SIGNATURE | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

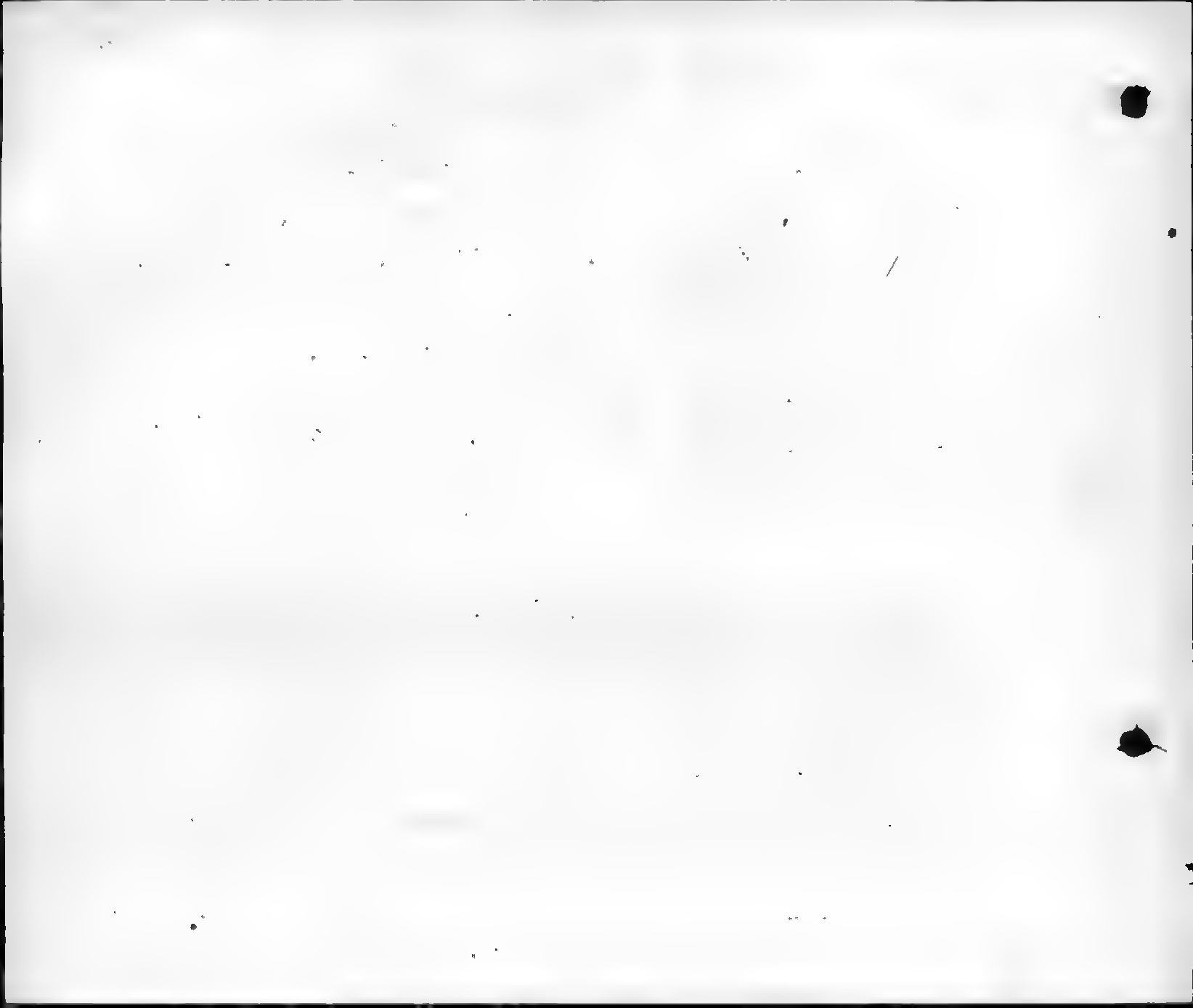
08833

8862

| | | | | | | | |
|--|---------------------------------|--|--|---|---|--|--|
| 1 PLACE OF DEATH a. COUNTY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived If inst. on Residence before admission) a. STATE Md. b. COUNTY Balto. | | | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville, | | | | c LENGTH OF STAY IN 1b | | | |
| d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5648 Calyn Rd. | | | | e CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville, | | | |
| f IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | g STREET ADDRESS 1130 Daniels Ave. | | | |
| 3 NAME OF DECEASED (Type or print) First SAMUEL Middle L. Last HUGHES, SR. | | | | 4. DATE OF DEATH Month AUG. Day 31 Year 1960 | | | |
| 5 SEX Male | 6 COLOR OR RACE white | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 6, 1895 | 9 AGE (in years last birthday) 65 yrs | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) lacinist | | 10b KIND OF BUSINESS OR INDUSTRY Crown, Cork Seal | | 11. BIRTHPLACE (State or foreign country) Baltimore Md. | | 12 CITIZEN OF WHAT COUNTRY? | |
| 13 FATHER'S NAME Charles H. Hughes | | | | 14 MOTHER'S MAIDEN NAME Hyland | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) NO | | 16 SOCIAL SECURITY NO. (If yes, give war or dates of service) NO | | INFORMANT Mrs. Viola Doering 3811 Woodley Ave. Balto | | | |
| 18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 72 years | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Periton | | | | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c TIME OF INJURY Month Day, Year Hour a. m. p. m. 19 | | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) | | 20f (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 8/30 , 19 60 , to 8/31 , 19 60 , that I lost saw the deceased alive on 8/30 , 19 60 , and that death occurred at 6:00 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE James Nolan | | | | ADDRESS (Street, city or town, state) 1 Mallow Hill Ave Baltimore Md. | | | |
| PHYSICIAN'S NAME (Type) J. J. NOLAN | | | | DATE SIGNED 9/1/60 | | | |
| 22a BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b DATE THEREOF 9-3-1960 | | 22c NAME OF CEMETERY OR CREMATORY Lorraine Park Co | | 22d LOCATION (City, town, or county) (State) Baltimore Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Thomas J. Kenny, Inc. 1600 Hollins St. | | | | 24a REC'D BY REGISTRAR DATE SEP 6 '60 | | 24b REGISTRAR'S SIGNATURE C. Chris S. Frank | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event with a 72 hours after death.



Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8863

CERTIFICATE OF DEATH

08834

| | | | | | | | |
|--|-------------------------------|--|-------------------------------------|---|--|--|-----------------------------|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colgate | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colgate | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | e. STREET ADDRESS 17287 Bridgwood Drive | | | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Clinton S Hutchinson | | | | 4. DATE OF DEATH Month Day Year August 11/60 19 | | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov 13 1898 | | 9. AGE (In years last birthday) 61 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher | | 10b. KIND OF BUSINESS OR INDUSTRY S K Co | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME John W Hutchinson | | | | 14. MOTHER'S MAIDEN NAME Margaret Young | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes If yes, give war or dates of service WW II | | | | 16. SOCIAL SECURITY NO. 213 05 2566 | | 17. INFORMANT Mrs Margaret Hutchinson Address 7287 Bridgwood Drive | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Cyst Carcinoma DUE TO (b) metastatic carcinoma of spine DUE TO (c) 3 mos Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | INTERVAL BETWEEN ONSET AND DEATH 3 mos | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Aug. 1 1960 to Aug. 12 1960 that (I) (we) last saw the deceased alive on Aug. 11 1960 , and that death occurred at 12:00 M, from the causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE John W Szezbicki M.D. | | | | 22b. DATE SIGNED | | | |
| 22c. PHYSICIAN'S NAME (Type) John W Szezbicki | | | | 22d. ADDRESS 1822 Eastern - Baltimore | | | |
| 23a. BURIAL CREMATION REMOVAL (Specify) burial | | 23b. DATE THEREOF Aug 15 /60 | | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | | 23d. LOCATION (City, town or county) (State) Baltimore Co | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home ADDRESS 2112 Dundalk Ave | | | | 25a. REC'D BY REGISTRAR AUG 16 '60 | | 25b. REGISTRAR'S SIGNATURE Charles S. Kline | |



CERTIFICATE OF DEATH

08835

8864

MEDICAL CERTIFICATION

VR A15 (4)
15M 9/59



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

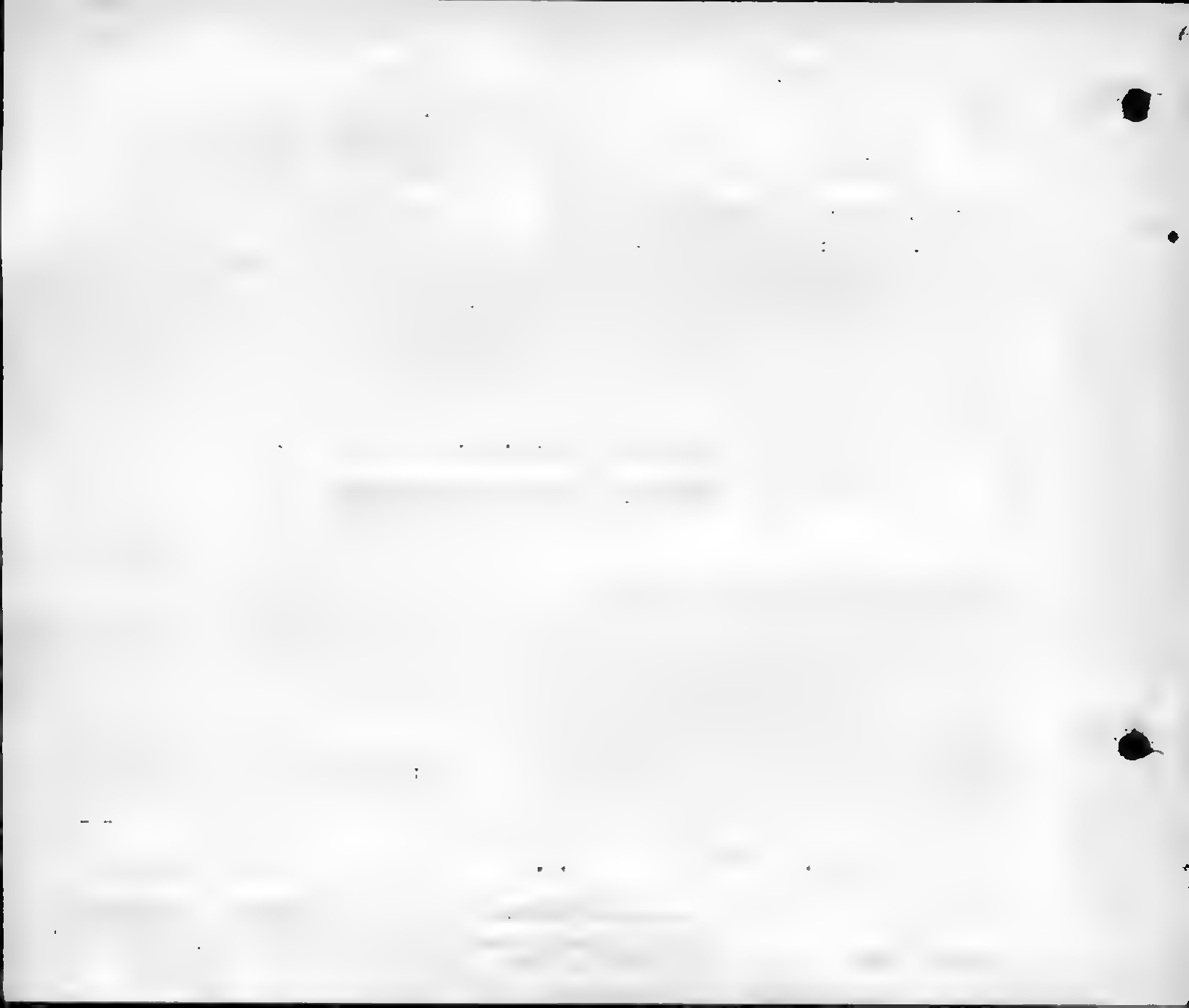
CERTIFICATE OF DEATH

08836

8865

Item 10 Baltimore City 8-15-60 et

| | | | |
|---|---------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY V | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE | |
| c. LENGTH OF STAY IN 1b 105 DAYS | | d. STREET ADDRESS 705 PIN ALLEY | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Served As: Calvin First CALVIN Middle Jarrett Last JARAD | | 4. DATE OF DEATH Month AUGUST Day 5 Year 1960 | |
| 5. SEX male | 6. COLOR OR RACE colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MAY 18, 1899 |
| 9. AGE (In years last birthday) 61 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USLA. OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Trucking Co | |
| 11. BIRTHPLACE (State or foreign country) Texas, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Charlie Jarad | | 14. MOTHER'S MAIDEN NAME Gertie Gibbs | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO None | |
| 17. INFORMANT Clin. Rec. VAH Balto 18, Md Ft Howard Division | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SARCOMA OF LUNG WITH METASTASES DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | |
| INTERVAL BETWEEN ONSET AND DEATH UNKNOWN | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (a) (this hospital) attended the deceased from April 22, 1960 to August 5, 1960 that (b) (we) last saw the deceased alive on August 5, 1960 , and that death occurred 1:15 PM from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Paul G. Koukoulas M.D. | | 22b. DATE SIGNED 8-7-60 | |
| 22c. PHYSICIAN'S NAME (Type) PAUL G. KOUKOULAS M.D. | | 22d. ADDRESS VAH BALTO 18, MD FT HOWARD DIVISION | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 8/10/60 | |
| 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL | | 23d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND | |
| 24. FUNERAL DIRECTOR'S SIGNATURE George W Queen | | 25a. REC'D BY REG STRAR AUG 9 '60 DATE | |
| 25b. REGISTRAR'S SIGNATURE William S. Frank | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12, 11, 10, 8, 5-8-11 et

CERTIFICATE OF DEATH

Reg. Dist. No.

08837

8865

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> 29 <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u> | |
| c. LENGTH OF STAY IN 1b <u>56 yrs</u> | | d. STREET ADDRESS <u>937 Elmridge Ave</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>937 Elmridge Ave</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>C. Katherine Jaras</u> | | 4. DATE OF DEATH Month Day Year <u>Aug 1 1960</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb 2 1883</u> |
| 9. AGE (In years last birthday) <u>77</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sailor</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Tailor</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Lithuanian</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>Lithuania</u> | |
| 13. FATHER'S NAME <u>Unknown</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>215-054248</u> | |
| 17. INFORMANT <u>Petras Jaras</u> | | Address <u>937 Elmridge Ave</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO <u>Myocardial infarction, 2 weeks before death</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>8-15-59</u> , 19 <u>59</u> , to <u>Aug 1 1960</u> , that I last saw the deceased alive on <u>Aug 1 1960</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2030 W. Kenner Ave, Balto 23</u> DATE SIGNED ACTUAL SIGNATURE <u>Albinas Klimas</u> M.D. PHYSICIAN'S NAME (Type) <u>ALBINAS KLIMAS</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>Aug 4 1960</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Lawton Park</u> | 22d. LOCATION (City, town, or county) (State) <u>Frederick Ave Baltimore</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. Kachauskas</u> | | 24a. RECEIVED BY REGISTRAR DATE <u>Aug 3 1960</u> | 24b. REGISTRAR'S SIGNATURE <u>Robert A. Smith</u> |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8867

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08838

Reg. Dist. No.

| | | | | | | | |
|--|---|---|--|--|--------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKDALE</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKDALE</u> | | | |
| c. LENGTH OF STAY IN 1b <u>7 YEARS</u> | | | | d. STREET ADDRESS <u>3513 ELLEN ROAD</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3513 ELLEN ROAD</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>EARLY</u> <u>HYTER</u> <u>JOHNSON JR.</u> | | | | 4. DATE OF DEATH Month Day Year <u>August</u> <u>4</u> <u>1960</u> | | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>SEPTEMBER 28 1916</u> | 9. AGE (In years last birthday) <u>43</u> yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DRIVER SALESMAN</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>RICE'S BAKERY</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>EARLY H. JOHNSON SR.</u> | | | | 14. MOTHER'S MAIDEN NAME <u>GRACE KELLAM</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> | | 16. SOCIAL SECURITY NO. <u>215-09-655</u> | | 17. INFORMANT <u>JANET M. JOHNSON - SAME</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS - ACUTE</u> <u>440.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MINUTES</u> DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS FATAL <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Clarence E. McWilliams</u> | | | | DATE SIGNED <u>August 4 1960</u> | | | |
| EXAMINER'S NAME (Type) <u>Clarence E. McWilliams M.D.</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>8-8-1960</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Fountain Park</u> | | 22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Spring Byers</u> | | | | ADDRESS <u>8728 Liberty Road</u> | | 24a. REC'D BY REGISTRAR DATE <u>AUG 9 '60</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>C. E. L. & H. L.</u> | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, with this word "pending" in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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8868

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08837

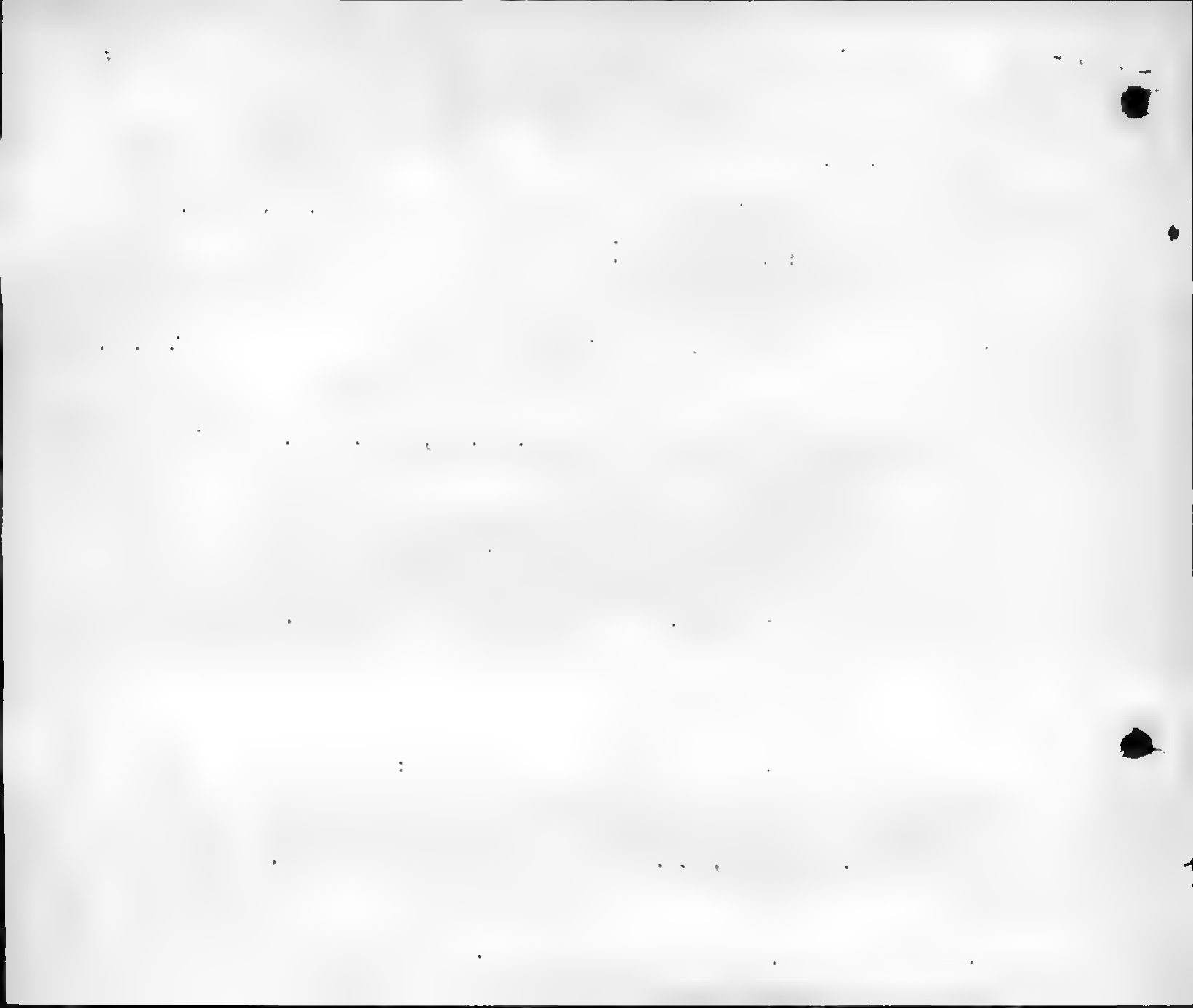
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|---|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|---|--|--|--|------------------------------------|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md. | | | | c. LENGTH OF STAY IN 1b 7 Days | | | | 2. USUAL RESIDENCE (Where deceased lived. If not at an residence before admission) a. STATE Maryland b. COUNTY 1 | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (19) | | | | | | | | | | | | | | | | | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) William H. JONES (Served as: William H. PROCASCO) | | | | 4. DATE OF DEATH Month August Day 18 Year 1960 | | | | 5. SEX Male | | | | 6. COLOR OR RACE White | | | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH April 29, 1894 | | | | 9. AGE (In years last birthday) 66 yrs | | | | 10. UNDER 1 YEAR Months Days Hours Min | | | | 11. UNDER 24 HRS Hours Min | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | | | | | | | 10b. KIND OF BUSINESS OR INDUSTRY Construction | | | | | | | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | | | | | | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | | | | | | | | | | | | |
| 13. FATHER'S NAME Charles Procasco | | | | | | | | 14. MOTHER'S MAIDEN NAME Rachel Jones | | | | | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes WW I | | | | | | | | 16. SOCIAL SECURITY NO 213-03-1563 | | | | | | | | 17. INFORMANT Clin. Rec. VAH, Balto. 18, Md. FORT HOWARD DIVISION | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO ACUTE SUPPURANT PERITONITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PERFORATED PEPTIC ULCER, DUODENUM (c) | | | | | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH RECENT RECENT RECENT | | | | | | | | | | | | | | | | | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Solitary Cyst, left kidney. Arteriosclerotic Heart Disease. | | | | | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | | | | 20f. (City or town) (County) (State) | | | | | | | | | | | | | | | |
| 21. I certify that (X) (this hospital) attended the deceased from August 11, 1960, to August 18, 1960, that (X) (we) last saw the deceased alive on August 18, 1960, and that death occurred at 10:45 P. M. from the causes and on the date stated above. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE FREDERICK S. DONALDSON, M.D. | | | | | | | | | | | | | | | | 22b. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION | | | | | | | | 22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D. | | | | | | | | 22d. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | | | 23b. DATE THEREOF 8-22-60 | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore, Maryland | | | | | | | | 23d. LOCATION (City, town or county) (State) | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook - Blight, Inc., 6009 Harford Road, Balto. 14 | | | | | | | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE AUG 24 '60 | | | | | | | | 25b. REGISTRAR'S SIGNATURE W. S. Kline | | | | | | | | | | | | | | | |

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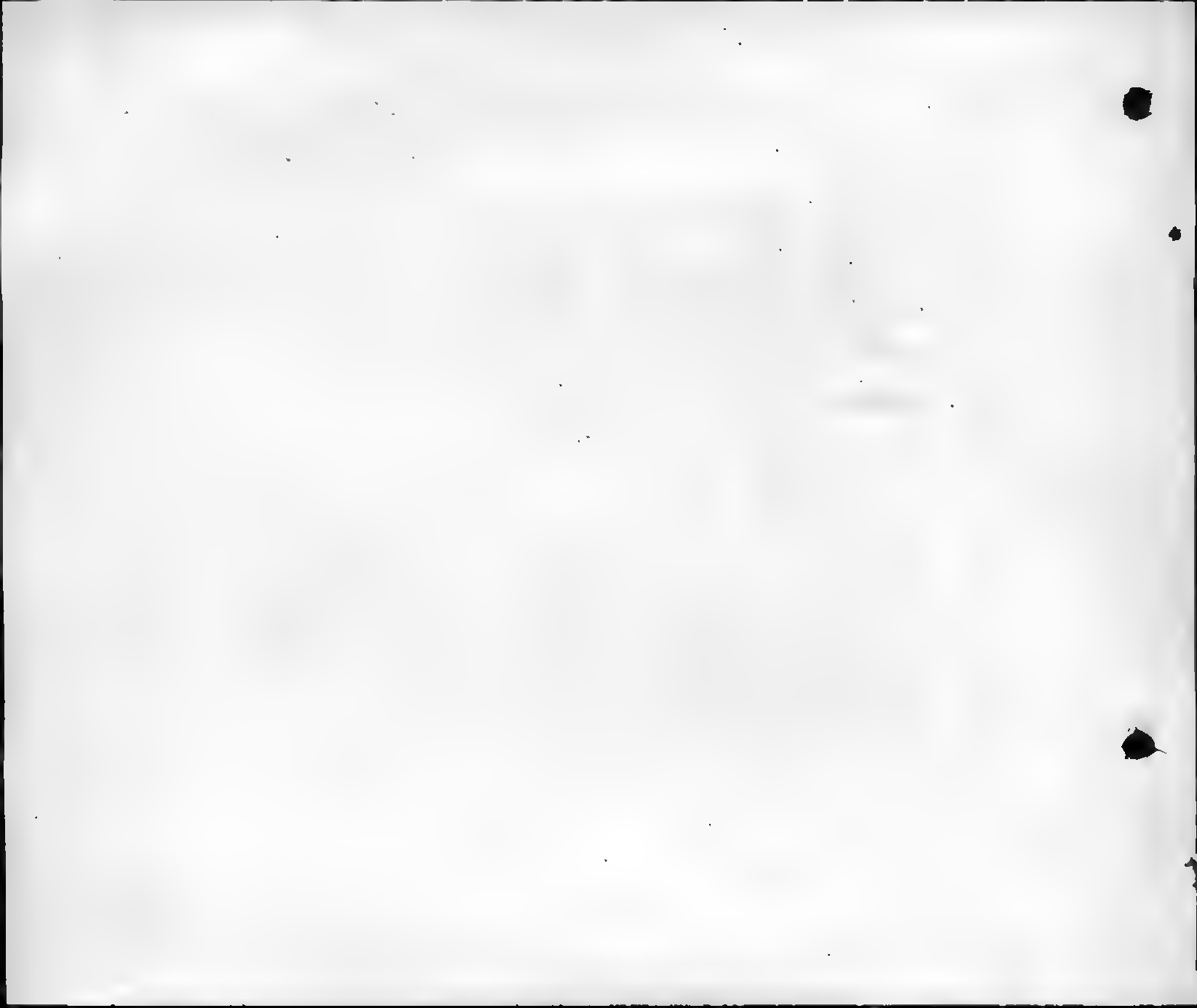
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Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8869
CERTIFICATE OF DEATH
08840

| | | | |
|--|-------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto.</u> | |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Calonsville</u> | | c. LENGTH OF STAY IN 1b <u>74. Howard P.O.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Forest Haven Home</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>OTTO</u> First <u>KAYES</u> Middle <u>KAYES</u> Last | | 4. DATE OF DEATH <u>Aug. 28</u> Month <u>Aug.</u> Day <u>28</u> Year <u>1960</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 1 1879</u> |
| 9. AGE (In years last birthday) <u>81</u> yrs | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> | 11. IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Straphman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>German</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Germany</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Nicodemus Kayer</u> | | 14. MOTHER'S MAIDEN NAME <u>Heller</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u> </u> | |
| 17. INFORMANT <u>Forest Haven Conv. Home Rec.</u> | | Address <u> </u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE</u> DUE TO (b) <u>PARTIAL-INTENSIVE DISEASE</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH <u> </u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | | 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u> | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan 15 1960</u> to <u>8/28 1960</u> , that (I) (we) last saw the deceased alive on <u>8/28 1960</u> and that death occurred at <u> </u> M, from the causes and on the date stated above | | | |
| 22a. SIGNATURE <u>John H. Shaw M.D.</u> | | 22b. DATE SIGNED <u>8/29/60</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>John H. Shaw M.D.</u> | | 22d. ADDRESS <u>5800 E. O'DONOVAN AVE. BALTO. MD.</u> | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) <u>Cremation</u> | | 23b. DATE THEREOF <u>8/30/60</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>London Park</u> | | 23d. LOCATION (City, town, or county) <u>Balto. Md</u> (State) <u> </u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>MacDuff + Son</u> | | ADDRESS <u>28</u> | |
| 25a. REC'D BY REGISTRAR <u> </u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u> | |
| DATE <u>AUG 31 '60</u> | | | |



8870

CERTIFICATE OF DEATH

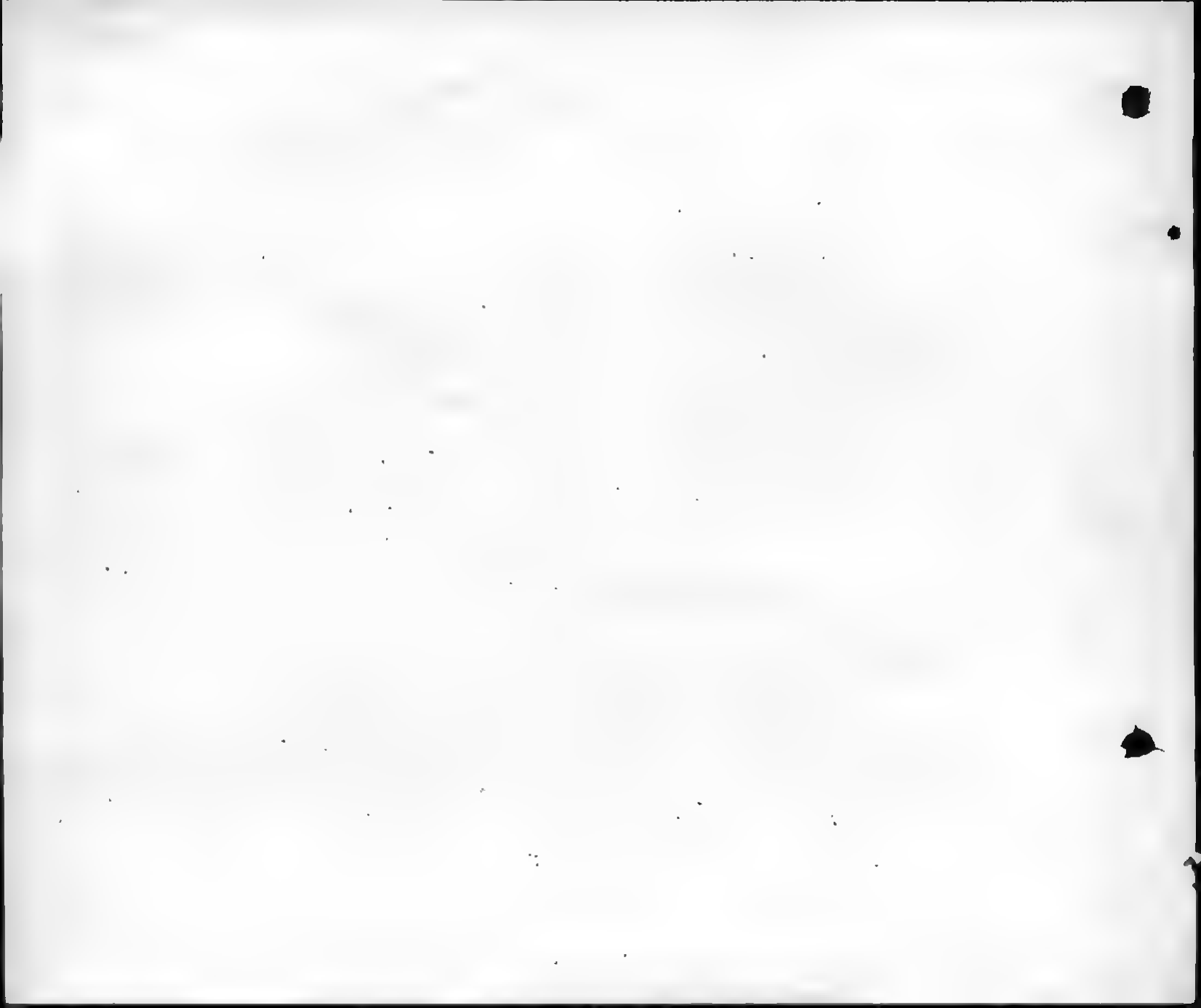
08841

Reg. Dist. No.

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Balto. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 5 Catonsville | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 20 Beaumont Ave. | | d. STREET ADDRESS 120 Beaumont Ave. | |
| 3. NAME OF DECEASED (Type or print) First Agnes Middle Lillian Last Kemp | | 4. DATE OF DEATH Month August Day 23 Year 1960 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 16, 1891 |
| 9. AGE (In years last birthday) 68 yrs | | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Health Nurse-Ret. | | 10b. KIND OF BUSINESS OR INDUSTRY Balto. City | |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Francis S. Kemp | | 14. MOTHER'S MAIDEN NAME Agnes L. Bffutt | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -- | | 16. SOCIAL SECURITY NO INFORMANT Address Miss Mary L. Kemp-20 Beaumont Ave. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Atrial Fibrillation (c) Generalized Atherosclerosis | | | INTERVAL BETWEEN ONSET AND DEATH 2 hr 10 years 6 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from June , 19 35 , to August 23, 1960 that I last saw the deceased alive on August 15, 1960 , and that death occurred at 9 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Wetherbee Fort M.D. | | ADDRESS (Street, city or town, state) 6 Sutton Ave, Catonsville, Md. | |
| PHYSICIAN'S NAME (Type) Wetherbee Fort | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 8-25-60 | 22c. NAME OF CEMETERY OR CREMATORY Cathedral Cem. | 22d. LOCATION (City, town, or county) (State) Balto. Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home-Catonsville, Md. | | 24a. REC'D BY REGISTRAR DATE AUG 29 '60 | 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.

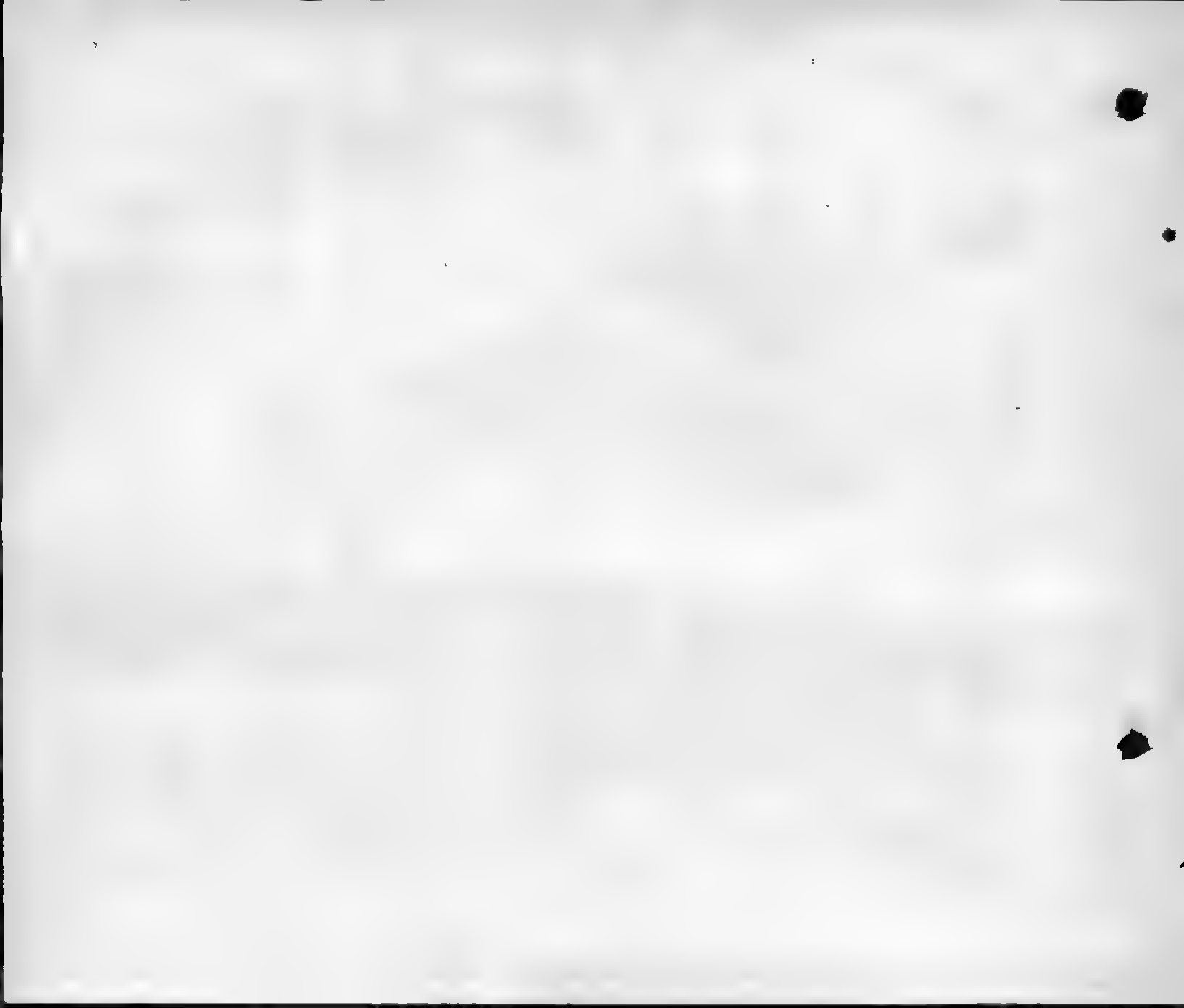
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



887

MEDICAL CERTIFICATION

VS. AISME(S)
SM 9/55



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8872

CERTIFICATE OF DEATH

Reg. Dist. No.

08843

| | | | |
|--|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDDLE RIVER | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDDLE RIVER Baltimore | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Ivy Hall Convalescent Home | | e. STREET ADDRESS 611 S. 40th St. 19 Harrison Ave-20 | |
| 3. NAME OF Mary First A. Middle Kestner Last | | 4. DATE OF DEATH Aug 22 1960 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 9, 1977 |
| 9. AGE (in years last birthday) 83 | | 10. IF UNDER 1 YEAR | 11. IF UNDER 24 HRS |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10b. KIND OF BUSINESS OR INDUSTRY HOUSE WORK | |
| 11. BIRTHPLACE (State or foreign country) BALTO., MD. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME ? LLOYD. | | 14. MOTHER'S MAIDEN NAME UNKNOWN. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO — | |
| 17. INFORMANT ANNA K. MEISENHOLDER | | Address 611 S. 46TH ST. BALTO., MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia DUE TO Sanguine left foot Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes mellitus (c) Arterio-sclerosis | | INTERVAL BETWEEN ONSET AND DEATH 2 mo 8 mo 2 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio-sclerosis | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Apr. 28, 1958 to Aug 22, 1960 , that I last saw the deceased alive on Aug 15, 1960 , and that death occurred at 11025 M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Joseph Nicoli M.D. | | ADDRESS (Street, city or town, state) 108 S. Taylor Ave DATE SIGNED 8/22/60 | |
| PHYSICIAN'S NAME (Type) JOSEPH NICOLI M.D. | | Early 21 Ind. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 8-25-60. | |
| 22c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEM. | | 22d. LOCATION (City, town, or county) (State) 7225 EASTERN BLVD. M.D. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Ziller ADDRESS 6224 EASTERN AVE. BALTO., MD. | | 24a. REC'D BY REGISTRAR AUG 26 '60 DATE | |
| 24b. REGISTRAR'S SIGNATURE James S. Kuntz | | | |

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فصل اول
در بیان احوال و عادات
و اخلاق و عادات

نورانی - احمدی

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Page 4

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

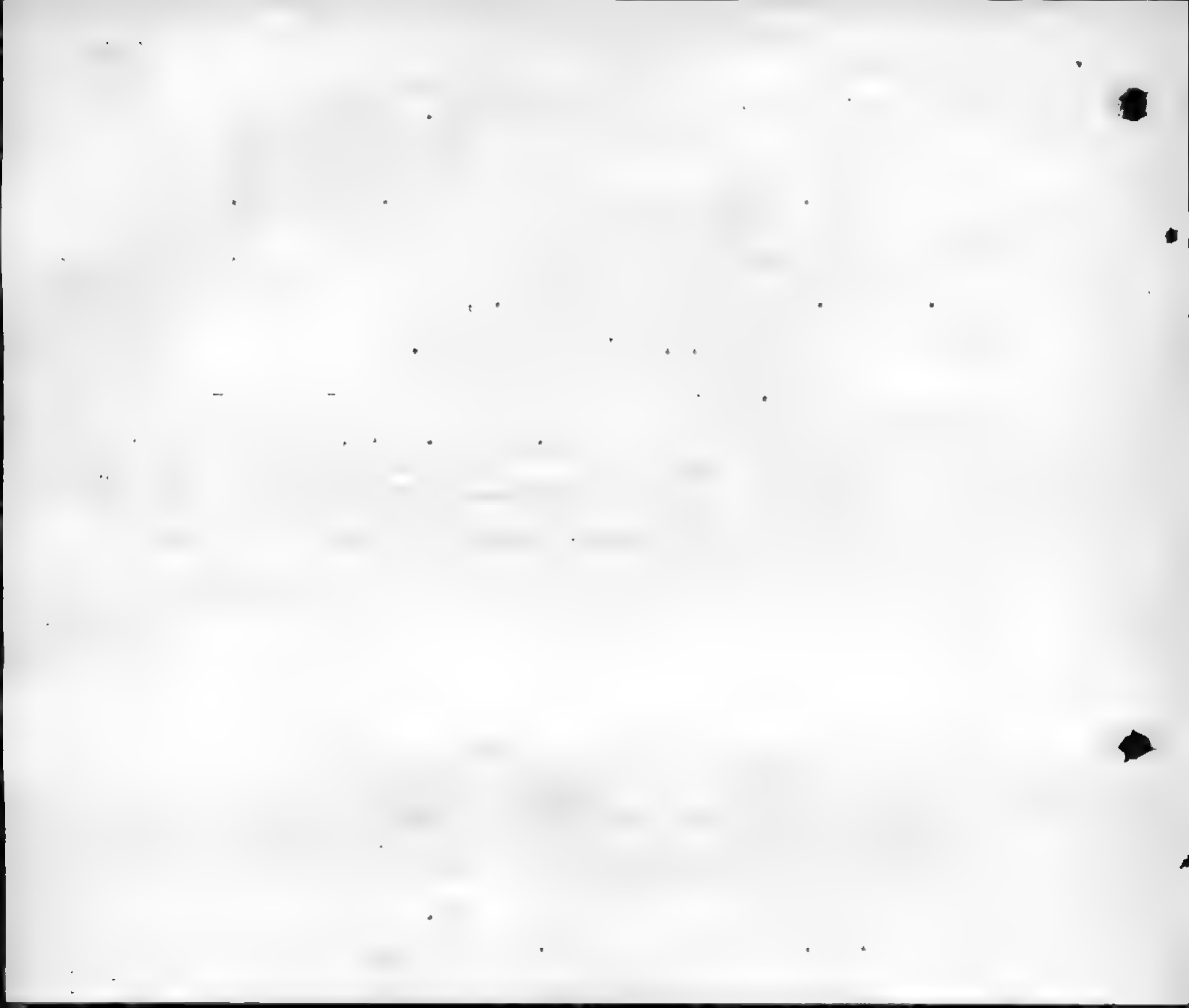
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8797

08844

(M)

| | | | | | | | |
|---|-------------------------------|--|---|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Relay | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1501 S.Rolling Rd | | | | e. STREET ADDRESS 1501 S.Rolling Rd. | | | |
| f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Robert Winfield Keyes | | | | 4. DATE OF DEATH Month Day Year Aug. 22 1960 | | | |
| 5. SEX M. | 6. COLOR OR RACE W. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Mar. 3, 1890 | 9. AGE (In years last birthday) 70 yrs | IF UNDER 1 YEAR Months Days Hours Min | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Electrician | | 10b. KIND OF BUSINESS OR INDUSTRY U.S.Gov'T | | 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Robert T. Keyes | | | | 14. MOTHER'S MAIDEN NAME Margaret----- | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> | | 16. SOCIAL SECURITY NO <input type="checkbox"/> | | 17. INFORMANT Mr. Henry W. Jones, 100 Belmore Rd. MD, | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) Myocardial Infarction Hypertensive U. S. C. V. D. | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from April 1959 to Aug 22, 1960 , that (I) (we) last saw the deceased alive on Aug 22, 1960 , and that death occurred at 9:00 PM , from the causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE W. J. Witzke M.D. | | | | 22b. DATE SIGNED 8/24/60 | | | |
| 22c. PHYSICIAN'S NAME (Type) W. J. Witzke | | | | 22d. ADDRESS 14101 Edmondson Ave. | | | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8/25/60 | | 23c. NAME OF CEMETERY OR CREMATORY Stone Chapel Cemty. | | 23d. LOCATION (City, town, or county) (State) Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Witzke Fun. Dir. 4101 Edmondson Ave. | | | | 25a. REC'D BY REG-STRAR DATE AUG 26 '60 | | 25b. REGISTRAR'S SIGNATURE William S. Jones | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
15M 9/59

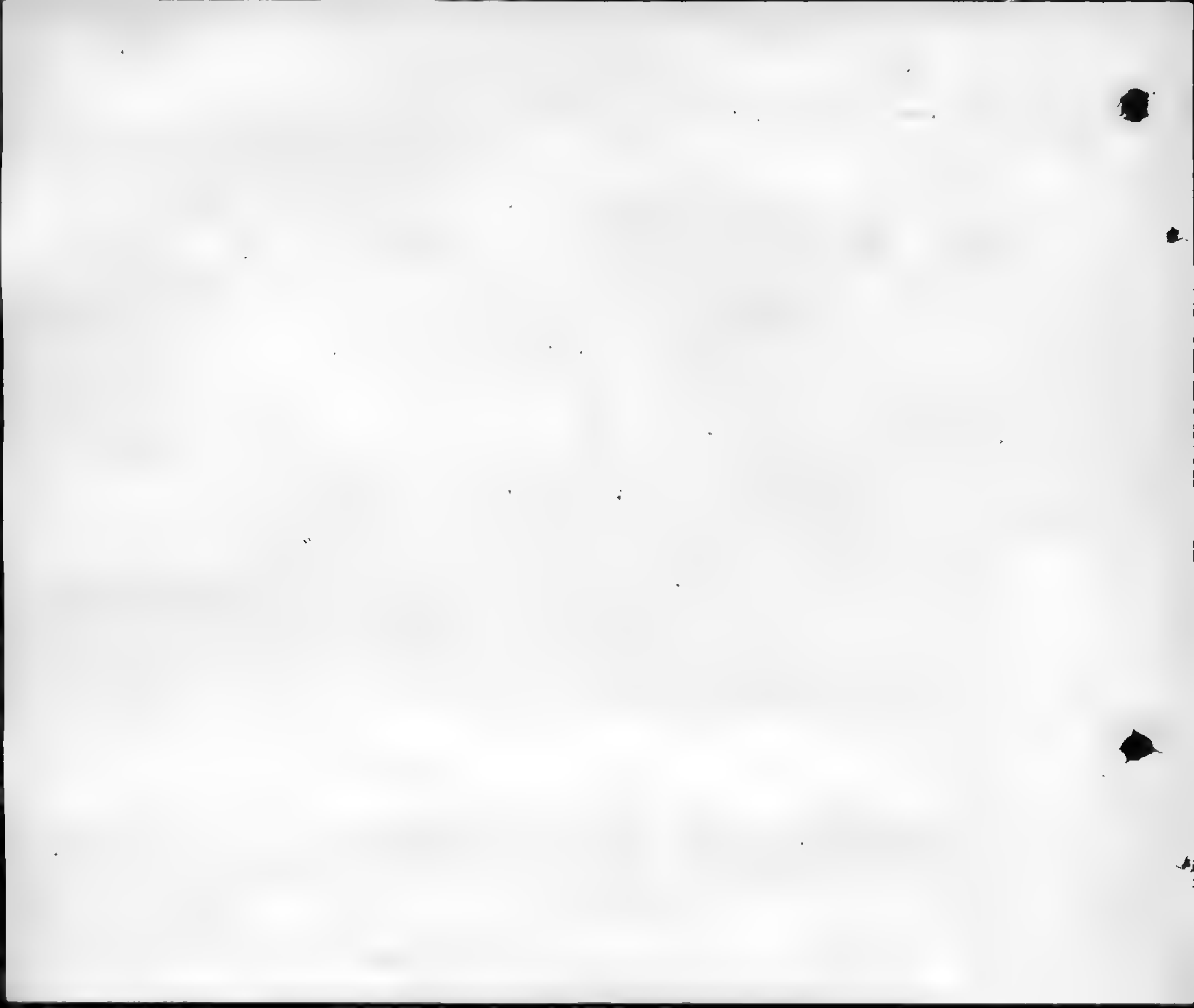
Item 18 Film 269 8-26-60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08845

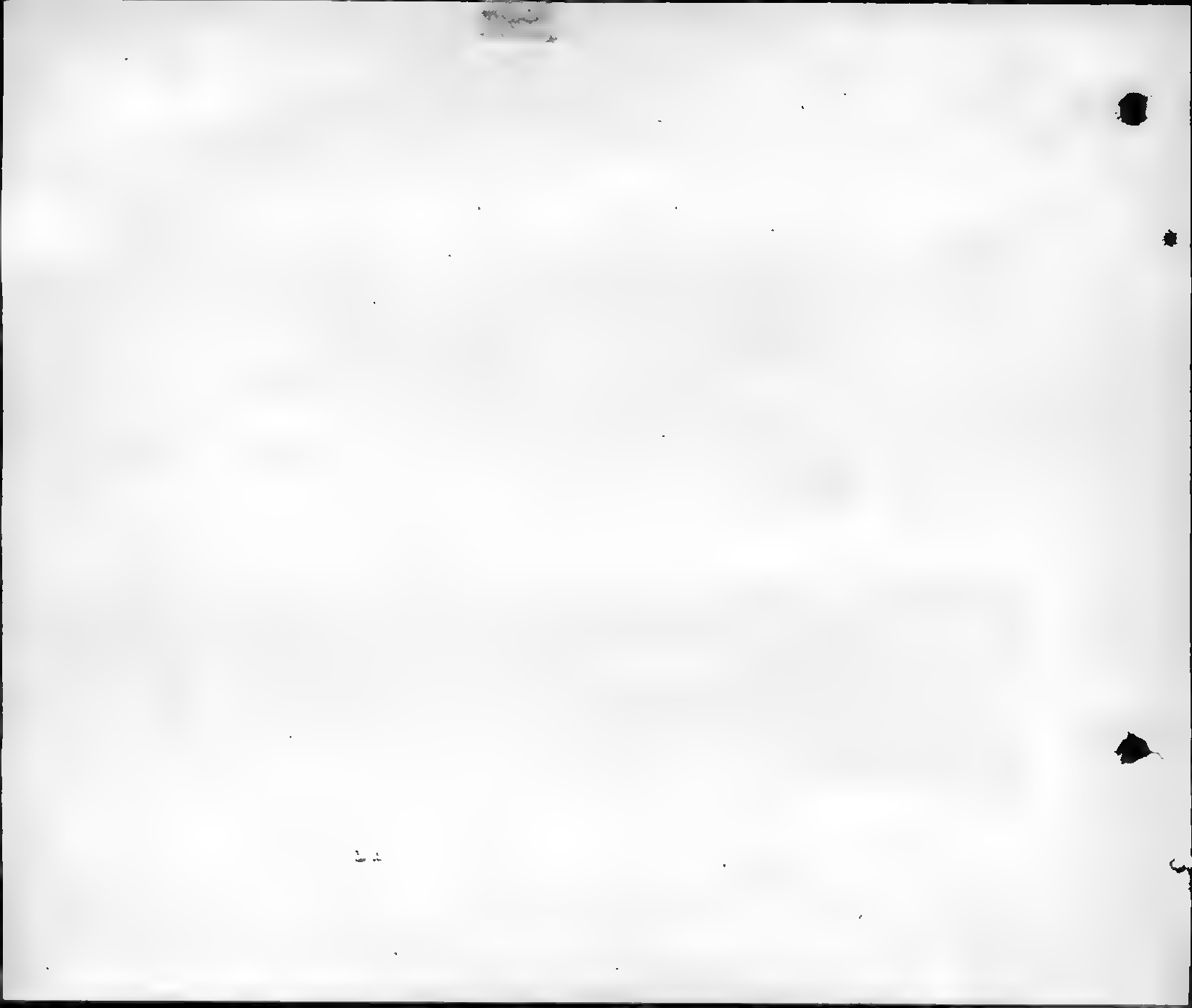
| | | | |
|---|-------------------------------|---|-----------------------------------|
| 1 PLACE OF DEATH a COUNTY <u>Baltimore</u> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Spring Grove St. Hosp.</u> c LENGTH OF STAY IN lb <u>1Y 3m 10D</u> d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove St. Hosp.</u> | | 2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Baltimore</u> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d STREET ADDRESS <u>2231 Annapolis Ave.</u> e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) <u>Herman Keyser</u> First Middle Last | | 4 DATE OF DEATH Month <u>8</u> Day <u>17</u> Year <u>1960</u> | |
| 5 SEX <u>Male</u> | 6 CO. OR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-25-1891</u> |
| 9 AGE (in years lost birthday) <u>69</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done; during most of working life, even if retired) <u>Unknown</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>James Keyser</u> | | 14. MOTHER'S MAIDEN NAME <u>Sarah H. H.</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>Unknown</u> | | 16. SOCIAL SECURITY NO <u>207-24-1051</u> | |
| 17. INFORMANT <u>Records Spring Grove Hospital</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <u>C.B.S. anoxia & cerebral arteriosclerosis</u> DUE TO <u>Arteriosclerotic cardiovascular disease</u> (c) <u>CVD & HTB with hypertension</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May 7</u> , 19 <u>60</u> , to <u>Aug. 17</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Aug. 17</u> , 19 <u>60</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above | | | |
| 22a. SIGNATURE <u>Stella Wachler</u> M.D. | | 22b. DATE SIGNED <u>8-18-60</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Stella Wachler, M.D.</u> | | 22d. ADDRESS <u>Spring Grove State Hosp.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>8-20-60</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Meadow Brook</u> | | 23d. LOCATION (City, town, or county) (State) <u>Wash. Blvd.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Johnson</u> | | 25a. REC'D BY REGISTRAR <u>2359 Wash. Blvd.</u> | |
| ADDRESS <u>2359 Wash. Blvd.</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u> | |
| DATE <u>AUG 19 1960</u> | | | |



Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8874
CERTIFICATE OF DEATH
08846

| | | | |
|--|---|--|--|
| 1 PLACE OF DEATH a. COUNTY <u>MARYLAND</u> | | 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 12</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 12</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WILLIAMS PULMONARY HOSPITAL</u> | | d. STREET ADDRESS <u>1305 E. MONROE ST.</u> | |
| 3 NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>WILLIAM</u> Last <u>WILLIAMS</u> | | 4. DATE OF DEATH Month <u>Aug</u> Day <u>1</u> Year <u>1960</u> | |
| 5 SEX <u>MALE</u> | 6 COLOR OR RACE <u>WHITE</u> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>SEPT 7, 1896</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MANAGER PUBLISHING</u> | | 9 AGE (In years last birthday) <u>63</u> yrs IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u> IF UNDER 24 HRS: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u> | |
| 11 BIRTHPLACE (State or foreign country) <u>UNITED STATES</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u> | |
| 13. FATHER'S NAME <u>JOSEPH WILLS</u> | | 14. MOTHER'S MAIDEN NAME <u>JANE THORNE</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>214-343699</u> | |
| 17. INFORMANT <u>ARTHUR WILLIAMS</u> | | Address <u>1305 E. MONROE ST.</u> | |
| 18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>4-20-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>ARTERIO-SCLEROTIC LARTIC-AL CALCIUM DEPOSITION</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>12 HRS</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> a. m. <u>19</u> p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21 I certify that (I) (this hospital) attended the deceased from <u>Nov 1, 1959</u> to <u>Aug 1, 1960</u> , that (I) (we) last saw the deceased alive on <u>July 31, 1960</u> , and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>THOMAS W. WILLIAMS</u> | | 22b. DATE SIGNED <u>Aug 1, 1960</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>THOMAS W. WILLIAMS</u> | | 22d. ADDRESS <u>1305 E. MONROE ST.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>AUG 3, 1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER CEMETERY</u> | 23d. LOCATION (City, town, or county) (State) <u>BALTIMORE MARYLAND</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>HENRY W. JENKINS & SONS CO</u> | | 25a. REC'D BY REGISTRAR <u>AUG 1 '60</u> | |
| ADDRESS <u>4905 YORK ROAD BALT MD</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hearn</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
8875
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
08847

| | | | | | | | |
|--|----------------------------------|---|-----------------------------------|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | | c. LENGTH OF STAY IN 1b 29yr3mth16dys | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | | | e. STREET ADDRESS 3529 Elliott Street | | | |
| 3. NAME OF DECEASED (Type or print) First Annie Middle Sophia Last Kintop | | | | 4. DATE OF DEATH Month August Day 21 Year 1960 | | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> separated WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-1895 | 9. AGE (in years last birthday) 65 yrs | IF UNDER 1 YEAR Months Days Hours Min | IF UNDER 24 HRS Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME John Strobel | | | | 14. MOTHER'S MAIDEN NAME Sophia Grapper | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO Unknown | | 17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Degeneration + Failure 287X (b) Essential Hypertension DUE TO (c) Obesity Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 1/2 months | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from July 23, 1960 to August 21, 1960 that (I) (we) last saw the deceased alive on August 21, 1960 , and that death occurred at 1139M , from the causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE Gertrude J. Fleischmann | | M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22b. DATE SIGNED Aug 21 1960 | | | |
| 22c. PHYSICIAN'S NAME (Type) GERTRUDE J. FLEISCHMANN | | 22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | | 23b. DATE THEREOF 8/24/60 | | 23c. NAME OF CEMETERY OR CREMATORY Moreland Park | | 23d. LOCATION (City, town, or county) (State) Baltimore Md | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck | | | | 25a. REC'D BY REGISTRAR DATE AUG 24 '60 | | 25b. REGISTRAR'S SIGNATURE Charles S. Frank | |



8876

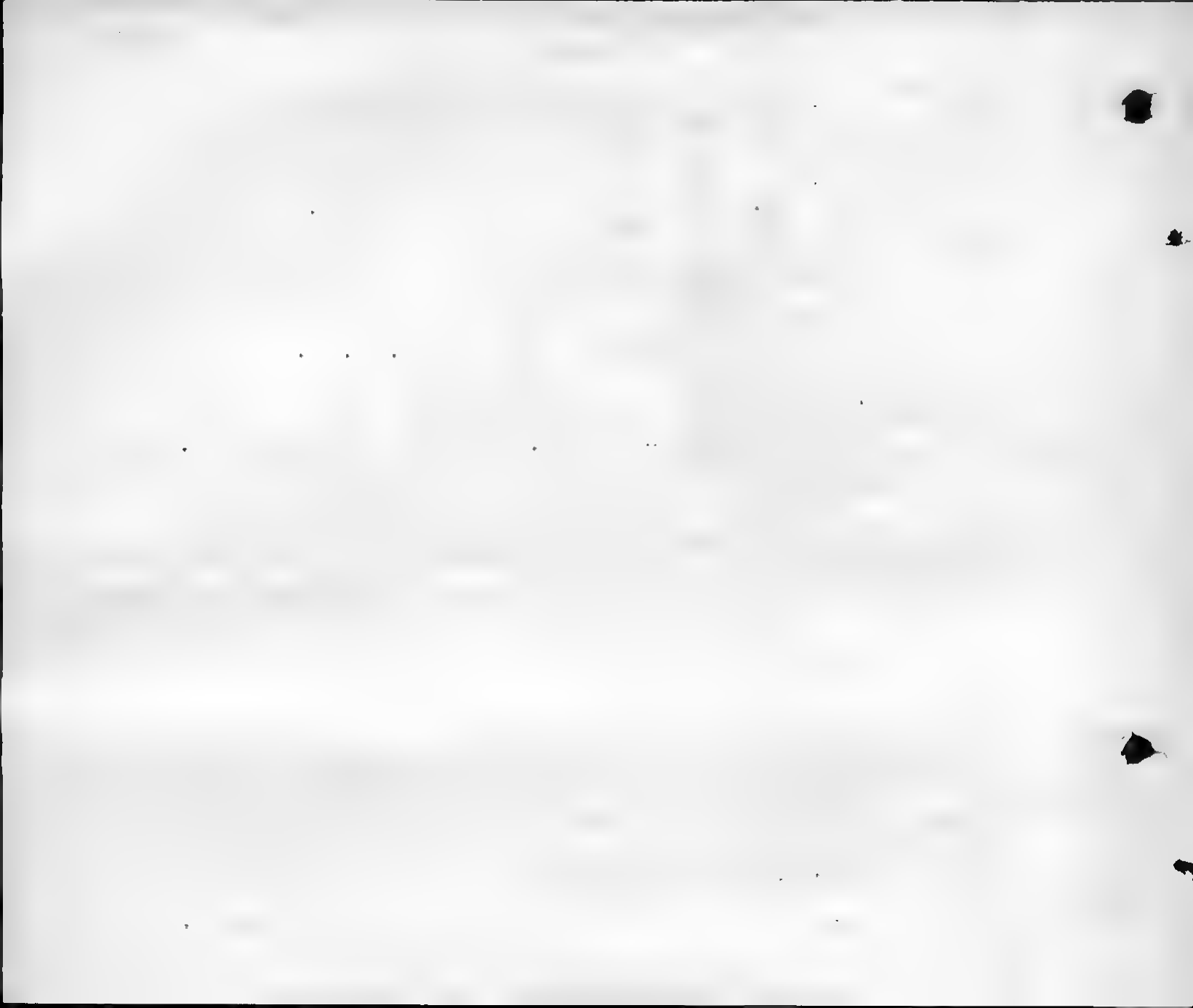
CERTIFICATE OF DEATH

08848

Reg. Dist. No.

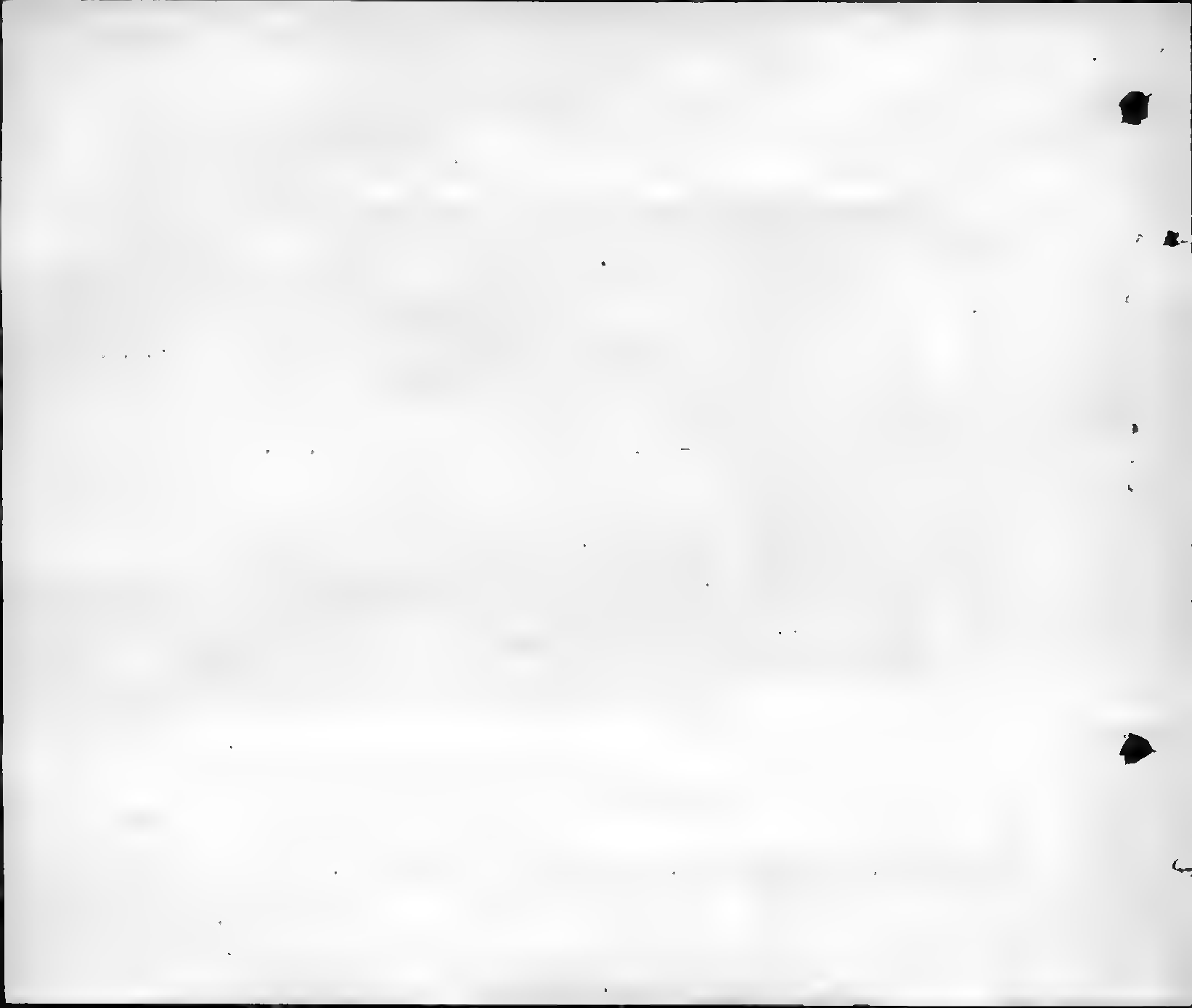
| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bradshaw</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bradshaw</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bradshaw Rd.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Louis</u> Middle <u>Koppleman</u> Last | | 4. DATE OF DEATH <u>Aug</u> Month <u>9</u> Day <u>1960</u> Year | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 4, 1891</u> |
| 9. AGE (In years last birthday) <u>69</u> yrs | | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>John H. Koppelman</u> | | 14. MOTHER'S MAIDEN NAME <u>Anna Schaub</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO <u>213-36-8313</u> | |
| 17. INFORMANT <u>Mrs. Emma Koppelman</u> | | Address <u>Bradshaw, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> DUE TO (b) <u>Arteriosclerotic CVD</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 mo. 3 yr.</u> |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>Aug.</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Aug. 8</u> , 19 <u>60</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>William A. Tyson</u> M.D. | | ADDRESS (Street, city or town, state) <u>Kingsville, Md.</u> DATE SIGNED <u>8-9-60</u> | |
| PHYSICIAN'S NAME (Type) <u>Wm. A. Tyson</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>8-13-1960</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u> | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William A. Tyson</u> ADDRESS <u>1701 N. ...</u> | | 24a. REC'D BY REGISTRAR <u>AUG 12 '60</u> DATE 24b. REGISTRAR'S SIGNATURE <u>Arthur L. ...</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the attending physician and completely filled in by the funeral director. This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 4 Days d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1030 Gough Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last ADA S. KOZLOWSKI | | | | 4. DATE OF DEATH Month Day Year August 11 1960 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH December 29, 1913 | |
| 9. AGE (In years last birthday) 46 | | 10. IF UNDER 1 YEAR Months Days Hours Min | | 11. IF UNDER 24 HRS Months Days Hours Min | | 12. IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver | | | | 10b. KIND OF BUSINESS OR INDUSTRY Trucking | | 11. BIRTHPLACE (State or foreign country) Biloxi, Mississippi | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 13. FATHER'S NAME Joseph Korlowski | | | |
| 14. MOTHER'S MAIDEN NAME Wanda Somuk | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWII | | | |
| 16. SOCIAL SECURITY NO. 217-05-1114 | | | | 17. INFORMANT Clinicords, VAH, Balto. Md. Ft. Howard Division | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CARDIAC DILATATION 710X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) RHEUMATIC HEART DISEASE WITH EXTREME MITRAL INSUFFICIENCY AND AORTIC STENOSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (c) CONGESTIVE HEART FAILURE | | | | | | | |
| 19. WAS A JUPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (this hospital) attended the deceased from August 7, 1960 , to August 11, 1960 , that (he) (we) saw the deceased alive on August 11, 1960 , and that death occurred 4:30 PM from the causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE Lawrence D. Marcus M.D. | | | | 22b. DATE SIGNED 8/11/60 | | | |
| 22c. PHYSICIAN'S NAME (Type) DR. LAWRENCE D. MARCUS | | | | 22d. ADDRESS VAH, BALTO. MD. FT. HOWARD DIVISION | | | |
| 23a. BURIAL CREMATION REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 8-16-60 | | 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL | | 23d. LOCATION (City, town or county) (State) BALTIMORE, MD. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook Blight Funeral Home, 6009 Lanford Rd., Balto., Md. | | | | 25a. REC'D BY REGISTRAR DATE AUG 15 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur J. F... | |



8873

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--|---|---|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived If institution Residence before adm ss an) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rose Dale | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rose Dale | |
| c. LENGTH OF STAY IN 1b 22 years | | d. STREET ADDRESS 805 Rose Dale Ave. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 805 Rose Dale Ave. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First Stanley Middle John Last Kozlowski | | 4. DATE OF DEATH Month Aug. Day 29 Year 1960 | |
| 5 SEX Male | 6. COLOR OR RACE White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 12, 1913 |
| 9 AGE (In years last birthday) 47 yrs. | | 10. IF UNDER 1 YEAR: Months 47 Days 47 Hours 47 Min 47 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic | | 10b. KIND OF BUSINESS OR INDUSTRY Railroad | |
| 11. BIRTHPLACE (State or foreign country) Boston, Mass. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 3. FATHER'S NAME John | | 14. MOTHER'S MAIDEN NAME Mary | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II | | 16. SOCIAL SECURITY NO. None | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Arteriosclerotic Cardio-Vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) 3 yes | | INTERVAL BETWEEN ONSET AND DEATH Sudden | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan 1, 1960 to Aug 29, 1960 that I last saw the deceased alive on Aug 28, 1960 and that death occurred at 10 P. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Philip E. Coach | | DATE SIGNED 8/31/60 | |
| PHYSICIAN'S NAME (Type) Baltimore Md | | ADDRESS (Street, city or town, state) | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Sept. 2, 1960 | 22c. NAME OF CEMETERY OR CREMATORY Baltimore National | 22d. LOCATION (City, town, or county) (State) Baltimore, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Philip E. Coach | | ADDRESS 1211 Chesaaco Ave. | |
| 24a. REC'D BY REGISTRAR SEP 2 '60 | | 24b. REGISTRAR'S SIGNATURE Charles E. Harris | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



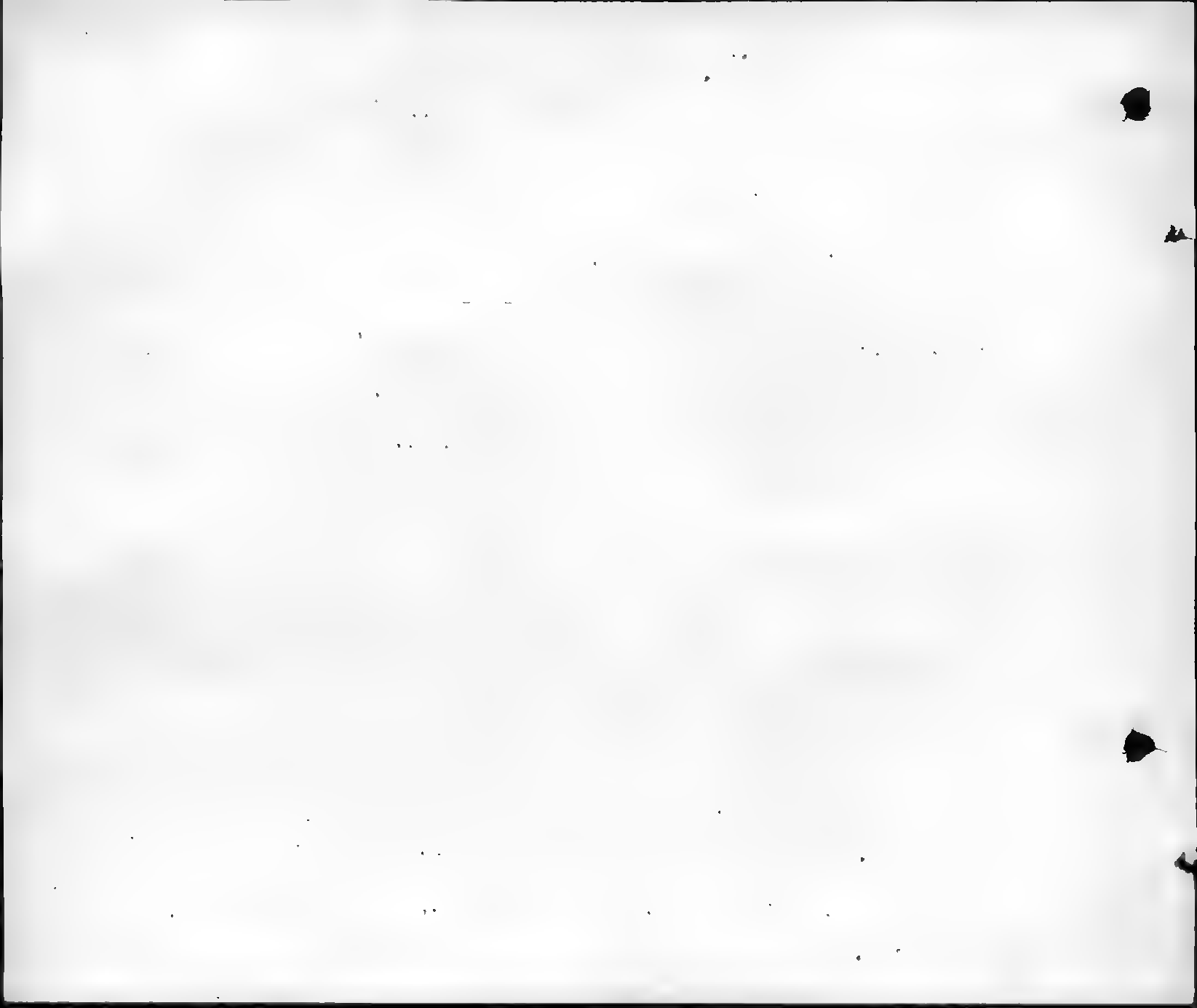
8879

CERTIFICATE OF DEATH

08851
Reg. Dist. No.

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7516 Hillsway</i> | | e. STREET ADDRESS <i>7516 Hillsway</i> | |
| 3. NAME OF DECEASED (Type or print) <i>Mrs. Eva P. Kramer</i> | | 4. DATE OF DEATH <i>August 8th 1960</i> | |
| 5. SEX <i>female</i> | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>8-26-1897</i> |
| 9. AGE (In years last birthday) <i>62</i> yrs | | 10. IF UNDER 1 YEAR <i>Months</i> <i>Days</i> <i>Hours</i> <i>Min</i> | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>floor lady</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Joseph Petza</i> | | 14. MOTHER'S M maiden NAME <i>Mary Antka</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>Informant Mrs Rita J. Wallace</i> Address <i>same</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: <i>1750</i> IMMEDIATE CAUSE (a) <i>Carcinoma of ovary with generalized metastasis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>1yr 3?</i> DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>9/26/1959</i> to <i>8/8/1960</i> , that I last saw the deceased alive on <i>8/6/1960</i> , and that death occurred at <i>9 A.M.</i> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Marion Friedman</i> M.D. | | ADDRESS (Street, city or town, state) <i>5211 Harford Road Baltimore, 14, Maryland</i> | |
| DATE SIGNED <i>8/8/60</i> | | | |
| PHYSICIAN'S NAME (Type) <i>MARION FRIEDMAN</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>8/12/60</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>St. Stanislaus Cem.</i> | 22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road #14</i> | | 24a. REC'D BY REGISTRAR DATE <i>AUG 9 '60</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> | |

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8880

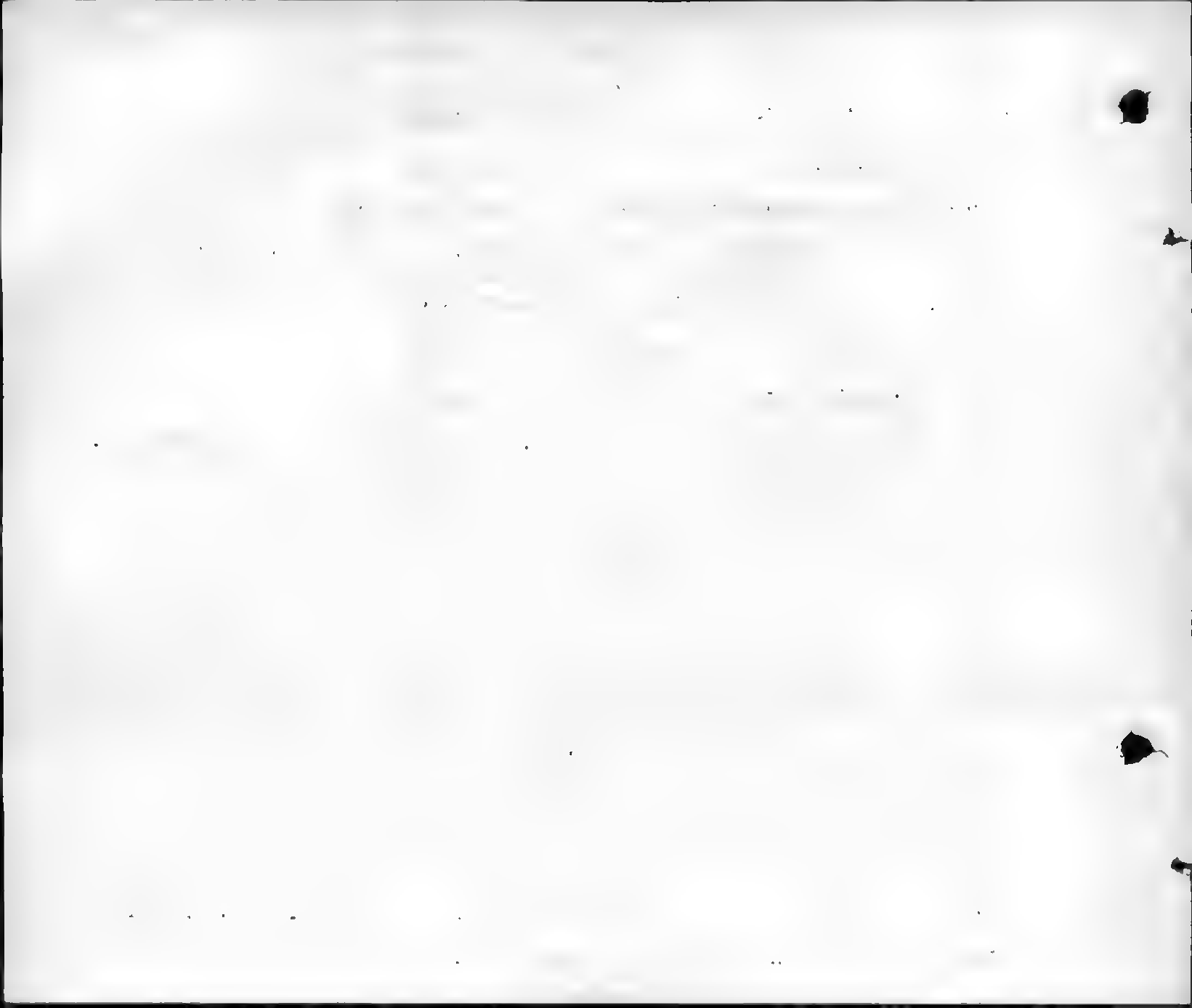
CERTIFICATE OF DEATH

Reg. Dist. No.

08852

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines Nursing Home | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| f. STREET ADDRESS 3319 Essex Road | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last MOLLIE SIEGEL KRETZER | | 4. DATE OF DEATH Month Day Year August 19 1960 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 10, 1887 |
| 9. AGE (In years last birthday) 73 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | 11. IF UNDER 24 HRS Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dressmaker | | 10b. KIND OF BUSINESS OR INDUSTRY Shop | |
| 11. BIRTHPLACE (State or foreign country) Poland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Gottlieb Siegel | | 14. MOTHER'S MAIDEN NAME Bertha ? | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. INFORMANT Mrs. Bertha Tuttleman Address 3319 Essex Rd. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Brain 192.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) None DUE TO (c) PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). None | | | INTERVAL BETWEEN ONSET AND DEATH 192 |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from June 1959 to 8/18 , 19 60 , that I last saw the deceased alive on 8/18 , 19 60 , and that death occurred at 3:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 332 W. 12th St. SD | | | |
| ACTUAL SIGNATURE Edward J. Fisher M.D. | | PHYSICIAN'S NAME (Type) Edward J. Fisher D.A. 470 (H.D.) | |
| 22a. BURIAL, CREMATION OR REMOVAL (Specify) Removal | 22b. DATE THEREOF 8/20/60 | 22c. NAME OF CEMETERY OR CREMATORY Baron-Hirsch Cemetery | 22d. LOCATION (City, town, or county) (State) Staten Island, New York |
| 23. FUNERAL DIRECTOR'S SIGNATURE Sol Levinson & Bros. Inc. ADDRESS 6010 Reisterstown Rd. Baltimore 15, Md. | | 24a. REC'D BY REGISTRAR DATE AUG 22 '60 | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

888

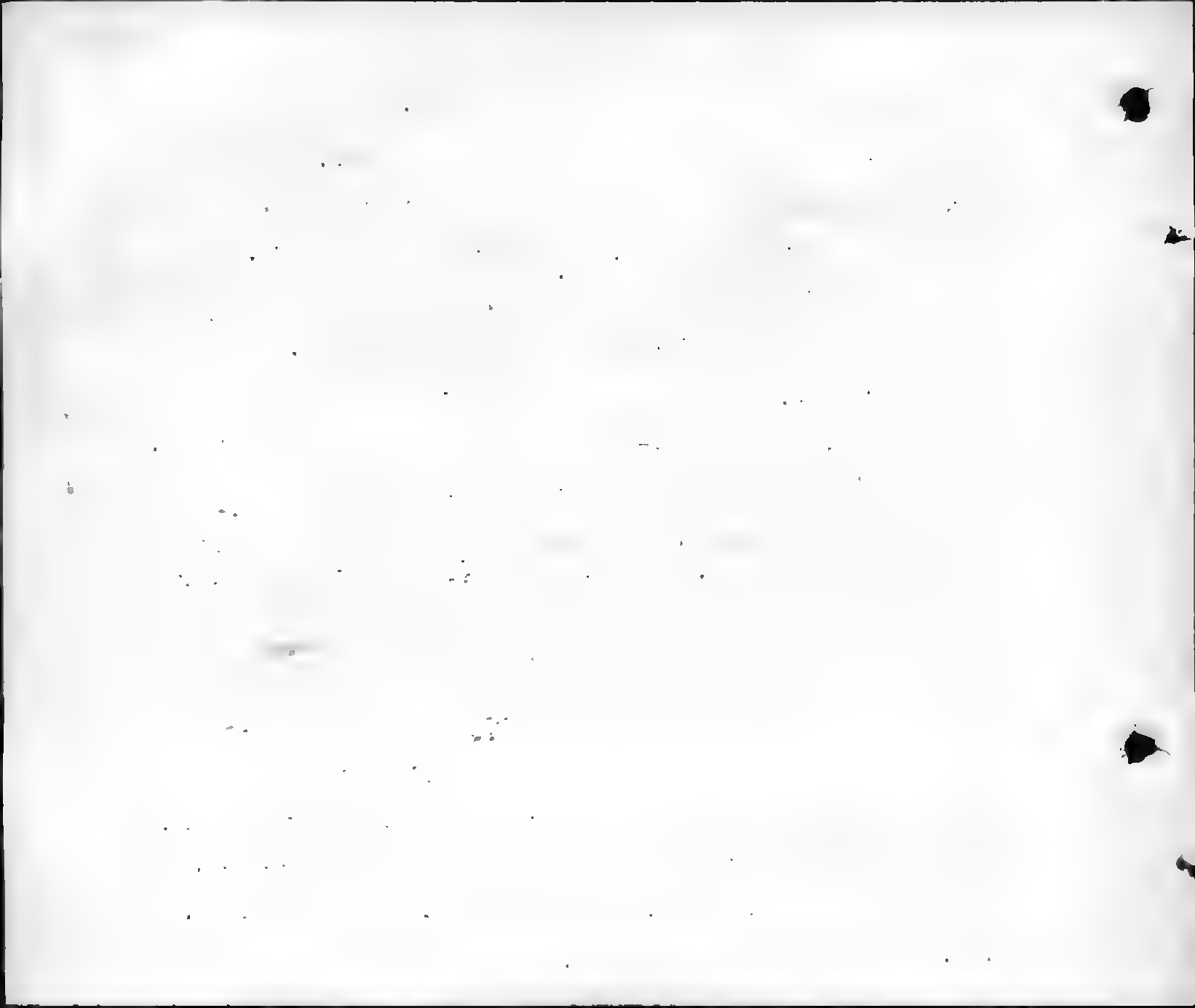
CERTIFICATE OF DEATH

Reg. Dist. No.

08853

| | | | |
|---|----------------------------------|--|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lochearn c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital give street address) OR INST. TIT. ON Augsburg Home | | 2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Md. b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Md. d. STREET ADDRESS 2627 Maryland Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First Lula Middle G. Last Kuhlemann | | 4. DATE OF DEATH Month Aug. Day 27 Year 19 60 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 22 1979 |
| 9. AGE (In years last birthday) 81 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | |
| 11 BIRTHPLACE (State or foreign country) Baltimore Md. | | 12 CITIZEN OF WHAT COUNTRY? | |
| 13 FATHER'S NAME Charles F. | | 14. MOTHER'S MAIDEN NAME Mary Schultheis | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give year or dates of service) No | | 16. SOCIAL SECURITY NO. 220-30-3187A | |
| INFORMANT Records | | Address 6811 Campfield Rd. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Angino Pectoris DUE TO (c) Acute Cardiac Failure with Pulmonary Odema | | | INTERVAL BETWEEN ONSET AND DEATH 5 yrs. 2 yrs. 3 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 19, 1960 , to Aug. 28, 1960 , that I last saw the deceased alive on Aug. 27, 1960 , and that death occurred at 10:15 A.M. , from the causes and on the date stated above. ADDRESS (Street city or town, state) 4108 Liberty Hgts Ave DATE SIGNED 8/28/60 | | | |
| ACTUAL SIGNATURE Earl L. Chambers | | PHYSICIAN'S NAME (Type) Earl L. Chambers 4108 Liberty Hgts Ave. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 8/31/60 | 22c. NAME OF CEMETERY OR CREMATORY St. Paul's Villetville | 22d. LOCATION (City town, or county) (State) Balto. Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE P. A. Heemann ADDRESS 6067 Harford Rd. | | 24a. REC'D BY REGISTRAR SEP 1 '60 | 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15M 9/59

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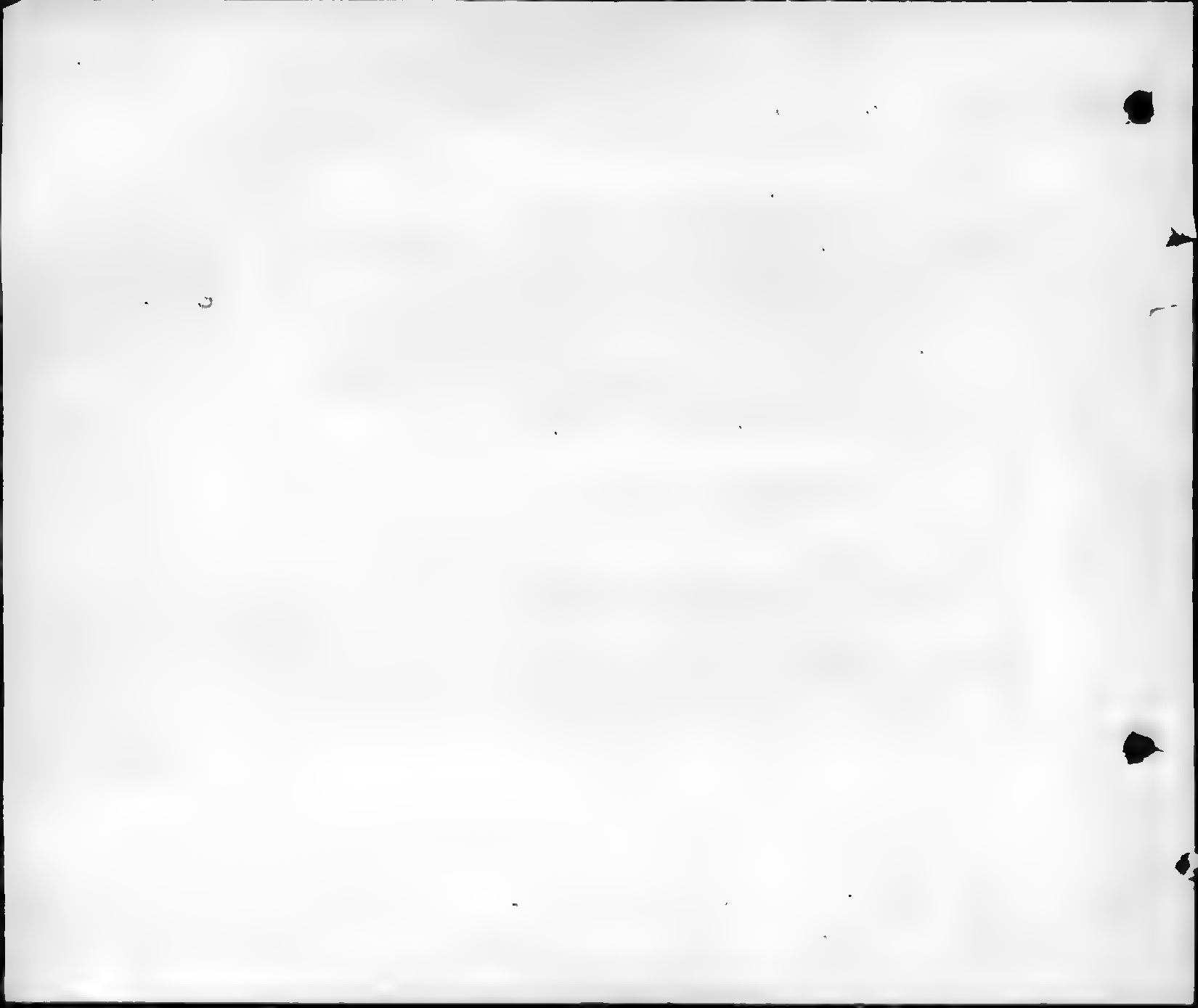
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8882

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08854

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MD b. COUNTY BALTO | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 20 | | c. LENGTH OF STAY IN 1b 54 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1537 ALBENEY | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First STEPHEN Middle LARICHIUTA Last LARICHIUTA | | 4. DATE OF DEATH Month AUG Day 2ND Year 1960 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JAN. 7-1960 |
| 9. AGE (In years last birthday) yrs 6 Months 26 Days 26 | | 10. F UNDER 1 YEAR 6 F UNDER 24 HRS 26 | |
| 10a. USLA. OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10b. KIND OF BUSINESS OR INDUSTRY — | |
| 11. BIRTHPLACE (State or foreign country) BALTO. MD | | 12. CITIZEN OF WHAT COUNTRY? — | |
| 13. FATHER'S NAME ALBERT LARICHIUTA | | 14. MOTHER'S MAIDEN NAME JOAN MOORE | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) — | | 16. SOCIAL SECURITY NO. — | |
| 17. INFORMANT PARENTS - SAME AS ABOVE | | Address — | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3444X DUE TO Hydrocephalus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO — (c) DUE TO — | | INTERVAL BETWEEN ONSET AND DEATH — | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) — | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) — | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. — | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — | | 20f. (City or town) (County) (State) — | |
| 21. I certify that (I) (this hospital) attended the deceased from 8-2 1960 to 8-2 1960 that (I) (we) last saw the deceased alive on 8-2 1960 and that death occurred at 11 M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Marvin Bromberg M.D. | | 22b. DATE SIGNED — | |
| 22c. PHYSICIAN'S NAME (Type) MARVIN BROMBERG | | 22d. ADDRESS 805 Fuschy Ave | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Aug 4-1960 | |
| 23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cem. | | 23d. LOCATION (City, town, or county) (State) German Hill Rd. Md | |
| 24. FUNERAL DIRECTOR'S SIGNATURE John G. Connolly | | 25a. REC'D BY REGISTRAR AUG 5 '60 | |
| 24. ADDRESS 418 Eastern Blvd Balto. Md | | 25b. REGISTRAR'S SIGNATURE Arthur S. Hines | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

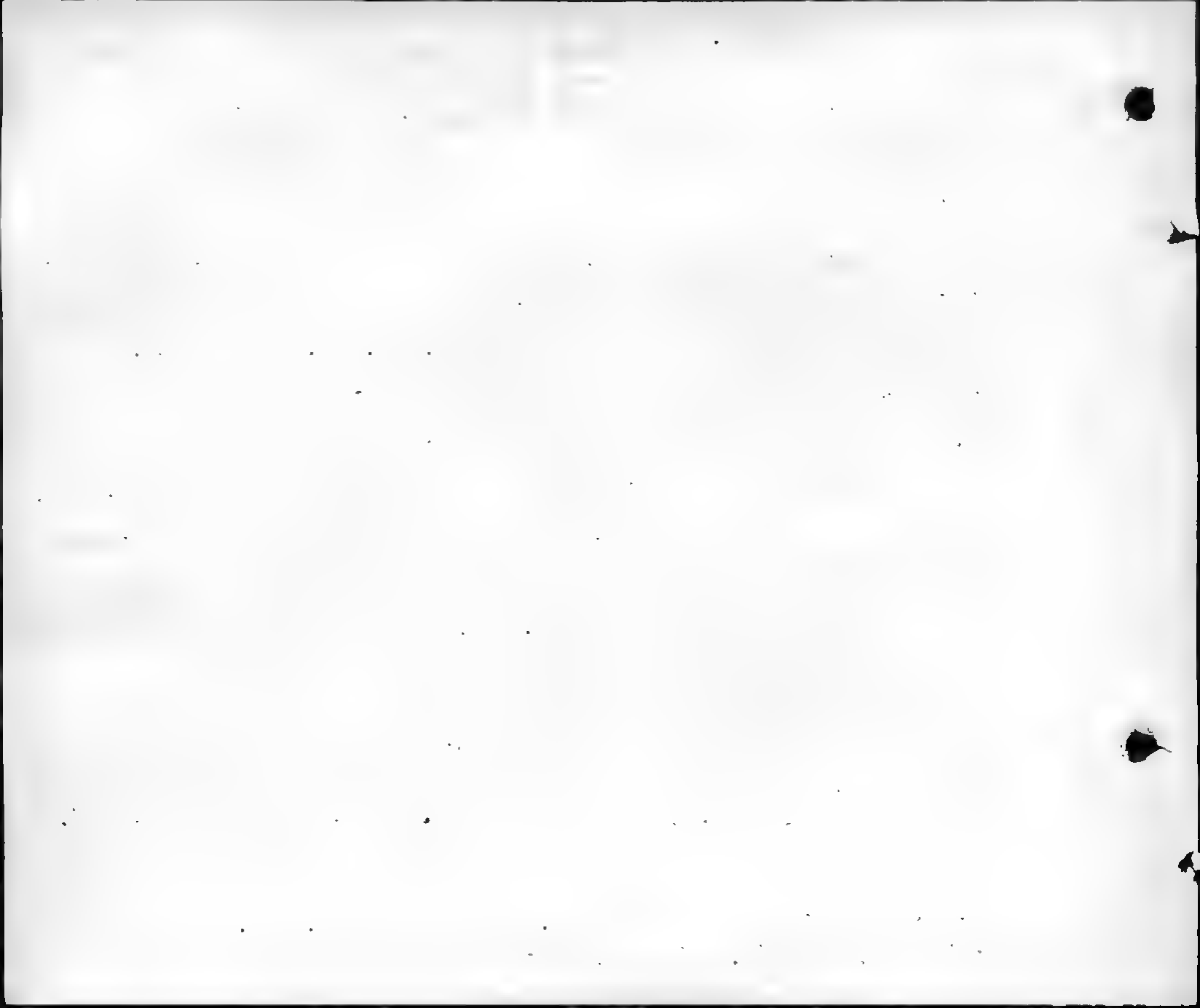
8883

CERTIFICATE OF DEATH

Reg Dist No 8855

| | | | |
|--|---------------------------------|---|---|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. STATE Maryland c. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Arm | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Arm | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Ferguson Road | | d. STREET ADDRESS Ferguson Road | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Katherine Elizabeth Laudenklos | | 4 DATE OF DEATH Month Day Year August 26, 19 60 | |
| 5 SEX Female | 6 COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-26-1875 |
| 9 AGE (in years last birthday) 85 | | 10. IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | |
| 11 BIRTHPLACE (State or foreign country) Balto., Co., Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Phillip Reichart | | 14. MOTHER'S MAIDEN NAME Katherine Schroeder | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO None | |
| INFORMANT Charles Laudenklos | | Address Ferguson Road | |
| 18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral & generalized arteriosclerosis DUE TO (c) 20 yrs | | | INTERVAL BETWEEN ONSET AND DEATH months |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic obstructive cardiac vascular disease | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from N.Y. , 1954, to Aug. , 1960, that I last saw the deceased alive on July 4, 19 60 , and that death occurred at 5:30 P.M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED Albert Harris, M.D. 8120 Harford Rd., Baltimore, Md. 8/22/60 | | | |
| ACTUAL SIGNATURE Albert Harris | | PHYSICIAN'S NAME (Type) Albert Harris | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8-30-60 | |
| 22c. NAME OF CEMETERY OR CREMATORY Parkwood Cem. | | 22d. LOCATION (City, town, or county) (State) Balto., Md. | |
| 23 FUNERAL DIRECTOR'S SIGNATURE Lassahn Sullivan 7401 Delmonte | | 24a. REC'D BY REGISTRAR DATE AUG 31 '60 | |
| 24b. REGISTRAR'S SIGNATURE William S. Kenna | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8884

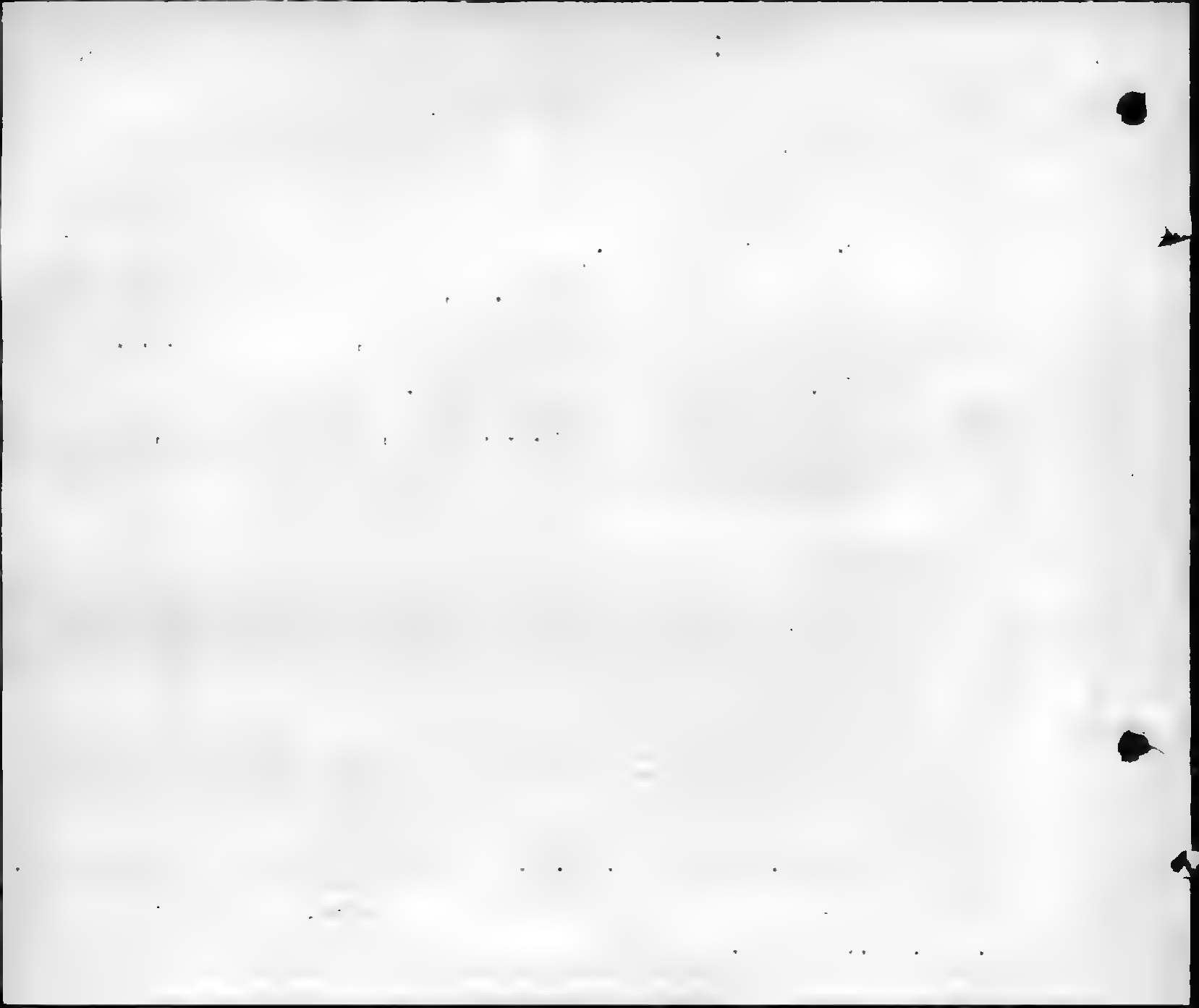
CERTIFICATE OF DEATH

Reg. Dist. No.

08856

| | | | |
|--|-------------------------------------|---|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12 | | c. LENGTH OF STAY IN TB | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Armagost Nursing Home 812 Regester Avenue | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4 | |
| f. STREET ADDRESS 546 Hampton Lane | | • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) Dr. Granville A. Lawrence | | 4. DATE OF DEATH Month August Day 8 Year 1960 | |
| 5 SEX Male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 30, 1883 |
| 9 AGE (In years and birthday) 76 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician | | 10b. KIND OF BUSINESS OR INDUSTRY | 11 BIRTHPLACE (State or foreign country) Philadelphia, Pa |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Thomas A. Lawrence | |
| 14 MOTHER'S MAIDEN NAME Mary E. Watson | | 15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. | | 17 INFORMANT Mrs. M. E. Whitney, 546 Hampton Lane, Towson 4 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4:20 p.m. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 2 hours | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cancer of vocal cord; treated; no metastases grossly | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Nov 19 , to Aug 19 , that I last saw the deceased alive on Aug 19 , and that death occurred at M , from the causes and on the date stated above ADDRESS (Street, city or town, state) 11 East Chase Street Baltimore 2, Md. DATE SIGNED 8/9/60 ACTUAL SIGNATURE Worth B. Daniels, Jr. M.D. 11 E. Chase St. PHYSICIAN'S NAME (Type) Worth B. Daniels, Jr., M. D. 11 East Chase Street Baltimore 2, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | 22b. DATE THEREOF 8-10-60 | 22c. NAME OF CEMETERY OR CREMATORY Hillside Cemetery | 22d. LOCATION (City, town, or county) (State) Roslyn, Pennsylvania |
| 23 FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street | | 24a. REC'D BY REGISTRAR DATE AUG 10 '60 | |
| 24b. REGISTRAR'S SIGNATURE Chas. S. King | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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VS ATS (4)
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8885

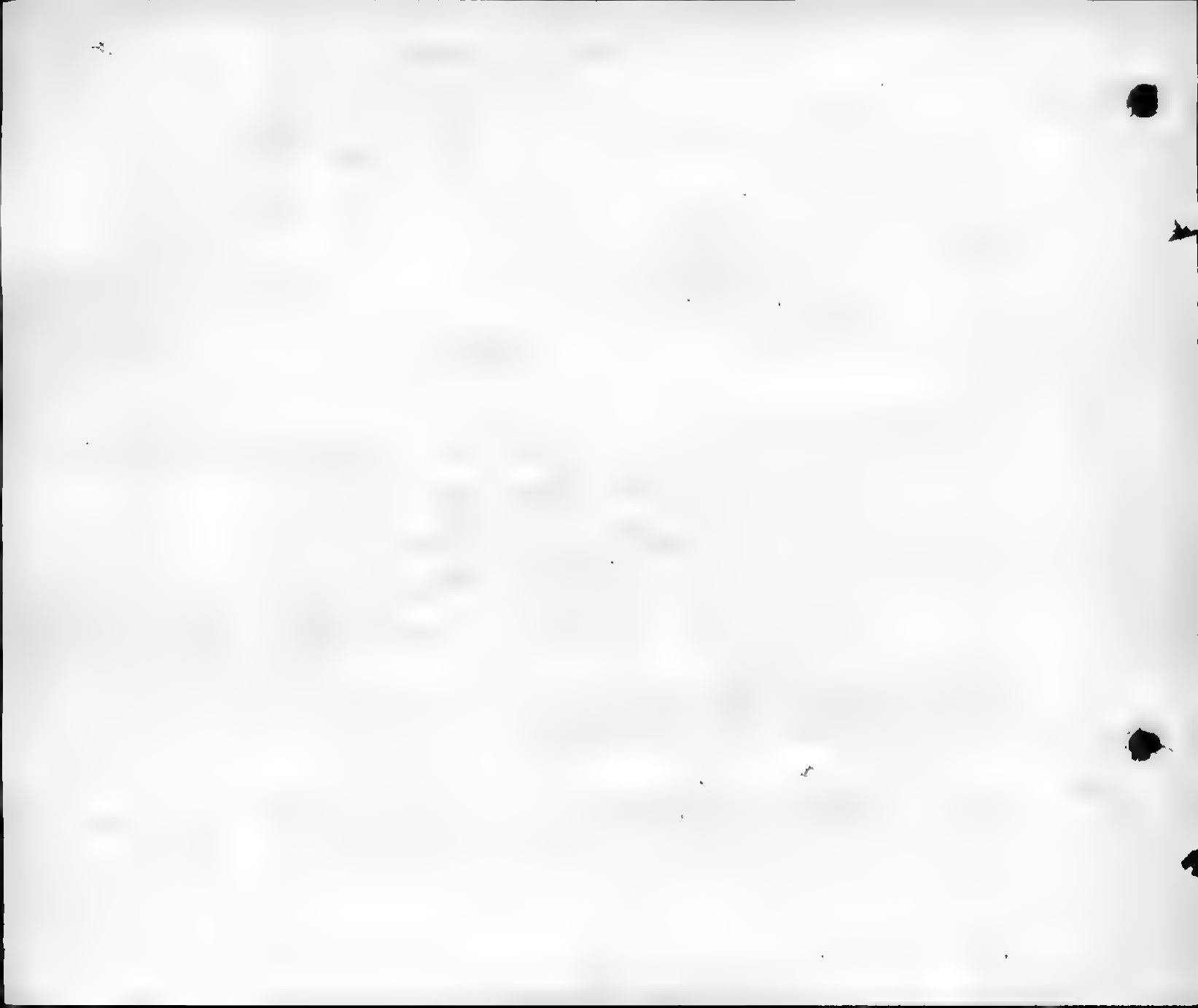
CERTIFICATE OF DEATH

Reg. Dist. No. 08857

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <i>Md</i> b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i> | | c. LENGTH OF STAY IN 1b <i>Baltimore</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>House in Lines</i> | | d. STREET ADDRESS <i>2625 Quaker Ave</i> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <i>GIOHIE - LEVIN</i> | | 4. DATE OF DEATH Month Day Year <i>8-5-1960</i> | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <i>Russia</i> |
| 13. FATHER'S NAME <i>Leyzer</i> | | 14. MOTHER'S MAIDEN NAME <i>Hinda</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or this town) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | INFORMANT <i>Leonard Levin - Son</i> Address |
| 18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <i>Acute Pyelonephritis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Paralysis agitans</i> (c) DUE TO <i>Generalized arteriosclerosis</i> | | | INTERVAL BETWEEN ONSET AND DEATH <i>2d</i> <i>1 yr</i> |
| PART II. OTHER SIGNIFICANT CONDITION CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Metastatic Ovarian Carcinoma 14 yrs</i> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>May 1959</i> to <i>August 60</i> , that I last saw the deceased alive on <i>Aug. 3</i> 19 <i>60</i> , and that death occurred at <i>2 P.M.</i> from the causes and on the date stated above ADDRESS (Street, city or town, state) <i>3600 Lochearn Dr</i> DATE SIGNED <i>5 Aug. 60</i> | | | |
| ACTUAL SIGNATURE <i>Daniel Dabel</i> | | M.D. <i>Baltimore Md</i> | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF <i>8-7-60</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>United Hebrew</i> | 22d. LOCATION (City, town, or county) (State) <i>Baltimore Md</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Frank L. ...</i> | | ADDRESS <i>2600 ...</i> | 24a. REC'D BY REGISTRAR DATE <i>AUG 8 '60</i> |
| | | 24b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

8888

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08858

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>6400 Bellona Ave.</u> | | c. LENGTH OF STAY IN 1b <u>6 months</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mercy Villa</u> | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air Rural</u> | |
| f. STREET ADDRESS <u>6400 Bellona Avenue</u> | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Cassandra A. Lochary</u> | | 4. DATE OF DEATH Month Day Year <u>August 27, 1960</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/28/71</u> |
| 9. AGE (In years last birthday) <u>88</u> yrs | 10. IF UNDER 1 YEAR Months Days Hours Min. | 11. BIRTHPLACE (State or foreign country) <u>Harford County, Maryland</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Public School</u> | |
| 13. FATHER'S NAME <u>John Lochary</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Wilson</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>John P. Lochary</u> | | Address <u>Balto. #6, Md. 6118 Alta Ave.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO (b) <u>Disease</u> (c) <u>10 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> to <u>8/27/60</u> that (I) <u>last</u> saw the deceased alive on <u>8/26/60</u> and that death occurred at <u>6:05 PM</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>John R. Davis, M.D.</u> | | 22b. DATE SIGNED <u>8/29/60</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>John R. Davis, M.D.</u> | | 22d. ADDRESS <u>401-402 Medical Arts Bldg., Balto., Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>8/30/60</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>St. Ignatius</u> | | 23d. LOCATION (City, town, or county) (State) <u>Bel Air (Rural) Harford County</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Fritz</u> | | 25a. REC'D BY REGISTRAR <u>W. Broadway & Williams St. BEL AIR, Maryland</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Travis</u> | | 25c. DATE <u>AUG 31 1960</u> | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

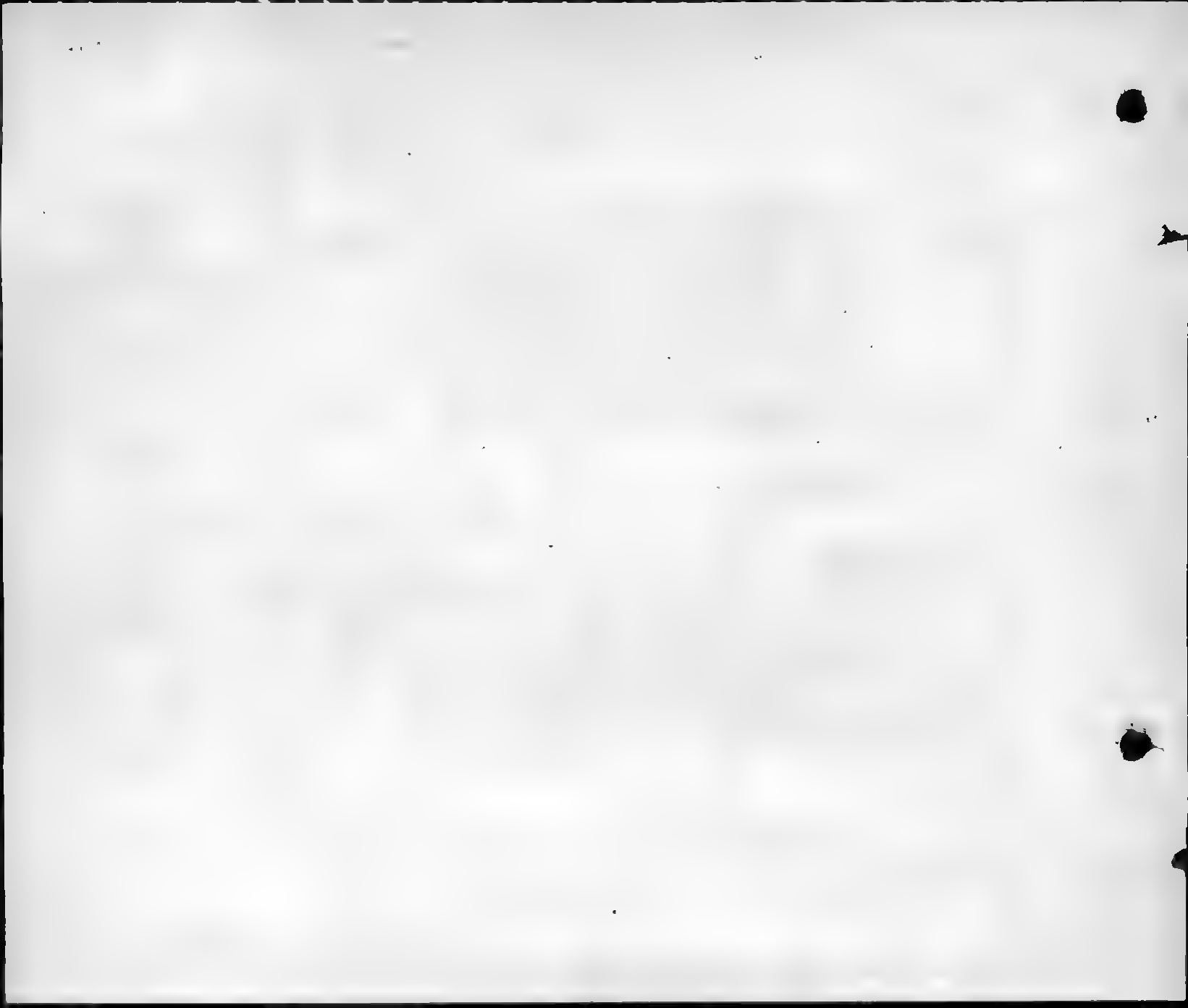
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08859

8887

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY BALTO MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE MD b. COUNTY BALTO | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTPOINT | | c. LENGTH OF STAY IN 1b EASTPOINT | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7814 WYNN BROOK | | d. STREET ADDRESS 7814 WYNN BROOK 1 | |
| 3. NAME OF DECEASED (Type or print) HASSIE First LOWE Middle LOWE Last | | 4. DATE OF DEATH Month AUG. Day 5 Year 1960 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH NOV-28-1904 55 yrs. |
| 9. AGE (In years last birthday) 55 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | 11. BIRTHPLACE (State or foreign country) KENTUCKY |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY AT HOME | 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
| 13. FATHER'S NAME WILLIAM I. LOWE | | 14. MOTHER'S MAIDEN NAME UNKNOWN | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — | | 16. SOCIAL SECURITY NO. — | 17. INFORMANT LANDY LOWE—SAME AS ABOVE |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO-SCLEROTIC-CARDIO-VASCULAR 102.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DISEASE DUE TO (c) — | | | INTERVAL BETWEEN ONSET AND DEATH — |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — | 20f. (City or town) (County) (State) — |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE M. B. DAVIS | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| NAME (Type) M. B. DAVIS MD | | DATE SIGNED 8/5/60 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | 22b. DATE THEREOF 8-6-1960 | 22c. NAME OF CEMETERY OR CREMATORY RIEVEVILLE, KENTUCKY | 22d. LOCATION (City, town, or county) (State) — |
| 23. FUNERAL DIRECTOR'S SIGNATURE John J. Connelly—418 Eastern Ave (Bldg 2) | | 24a. REC'D BY REGISTRAR AUG 16 '60 | 24b. REGISTRAR'S SIGNATURE Carlton S. Kline |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8888

CERTIFICATE OF DEATH

Reg. Dist. No

08860

| | | | | | | | |
|---|----------------------------------|---|---|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | | c. LENGTH OF STAY IN 1b 1 day | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Joseph's Nursing Home | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First MARY Middle LUCZKOWSKI Last | | | | 4. DATE OF DEATH Month August Day 6 Year 19 60 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 22, 1876 | 9. AGE (In years last birthday) 84 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY --- | | 11. BIRTHPLACE (State or foreign country) Poland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Lawrence Kozlowski | | | | 14. MOTHER'S MAIDEN NAME Victoria Jablonska | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address Mr. Joseph Luczkowski, 1005 S. East Avenue | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Senile Arteriosclerosis +50-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <input type="checkbox"/> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year Hour a. j. 19 p. m. | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Aug. 4, 1960 to Aug. 4, 1960 , that I last saw the deceased alive on Aug. 4, 1960 , and that death occurred at 11 a. M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Wm J. Schmitz M.D. | | | | ADDRESS (Street, city or town, state) 701 N. Kenwood Ave. DATE SIGNED 8/8/60 | | | |
| PHYSICIAN'S NAME (Type) Wm J. Schmitz | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/10/60 | | 22c. NAME OF CEMETERY OR CREMATORY Holy Rosary | | 22d. LOCATION (City or town or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. F. SADOWSKI & SONS, 1808 EASTERN AVENUE | | | | 24a. REC'D BY REGISTRAR DATE AUG 9 '60 | | 24b. REGISTRAR'S SIGNATURE Clara S. K... | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



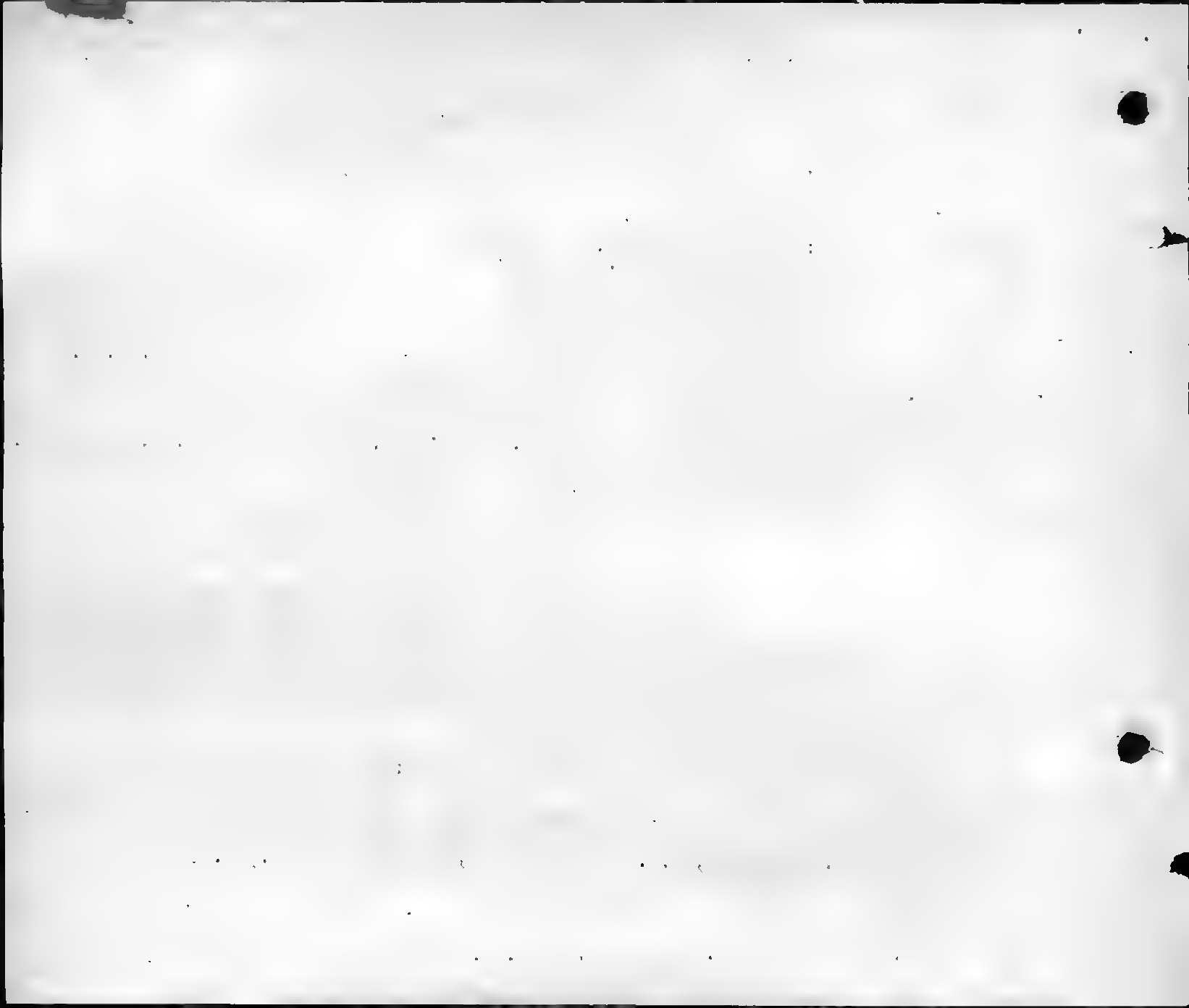
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8888

188861

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|---|------|-------|-----|---|--|---|--|---|--|--|--|---|--|--|--|--------|------|-------|-----|--|--|--|--|
| 1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard, Md.</u> c. LENGTH OF STAY IN 1b <u>54 Days</u> | | | | 2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore (17)</u> d. STREET ADDRESS <u>1607 McCulloh Street</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | |
| 3 NAME OF DECEASED (Type or print) <u>Served as: (First Samuel V. Mackall) Last MACKALL</u> | | | | 4. DATE OF DEATH Month <u>August</u> Day <u>14</u> Year <u>1960</u> | | 5 SEX <u>Male</u> | | 6 COLOR OR RACE <u>Negro</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>October 17, 1889</u> | | 9. AGE (In years last birthday) <u>70</u> y's <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </table> | | Months | Days | Hours | Min | | | | |
| Months | Days | Hours | Min | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11 BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u> | | | | 12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | | | | | | | | | |
| 13. FATHER'S NAME <u>James S. Mackall</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Harriett Thomas</u> | | | | | | | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> <u>WW I</u> | | | | 16 SOCIAL SECURITY NO. <u>215-09-6866</u> | | 17 INFORMANT <u>Clin. Recored, VAH, Baltimore</u> | | 18, Md. Ft. Howard Div. | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF STOMACH</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>151X</u> DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part or Part I of item 18) | | | | | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>19</u> p. m. | | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | | | | | | | | | | |
| 21 I certify that (1) (this hospital) attended the deceased from <u>June 21, 1960</u>, to <u>August 14, 1960</u>, that (1) (we) last saw the deceased alive on <u>August 14, 1960</u>, and that death occurred at <u>10:45 PM</u> from the causes and on the date stated above | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE <u>FREDERICK S. DONALDSON, M.D.</u> | | | | | | ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22b. DATE <u>8/15/60</u> | | | | | | | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>FREDERICK S. DONALDSON, M.D.</u> | | | | | | 22d. ADDRESS <u>VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION</u> | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 23b. DATE THEREOF <u>8-14-60</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u> | | | | 23d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | | | | | | | | | | | | | |
| 24 FUNERAL DIRECTOR'S SIGNATURE <u>Herbert E. Nutter, 3035 W. North Ave. Balto. Md.</u> | | | | | | 25a. REC'D BY REGISTRAR <u>DATE AUG 23 '60</u> | | 25b. REGISTRAR'S SIGNATURE <u>C. L. H. H.</u> | | | | | | | | | | | | | | | |

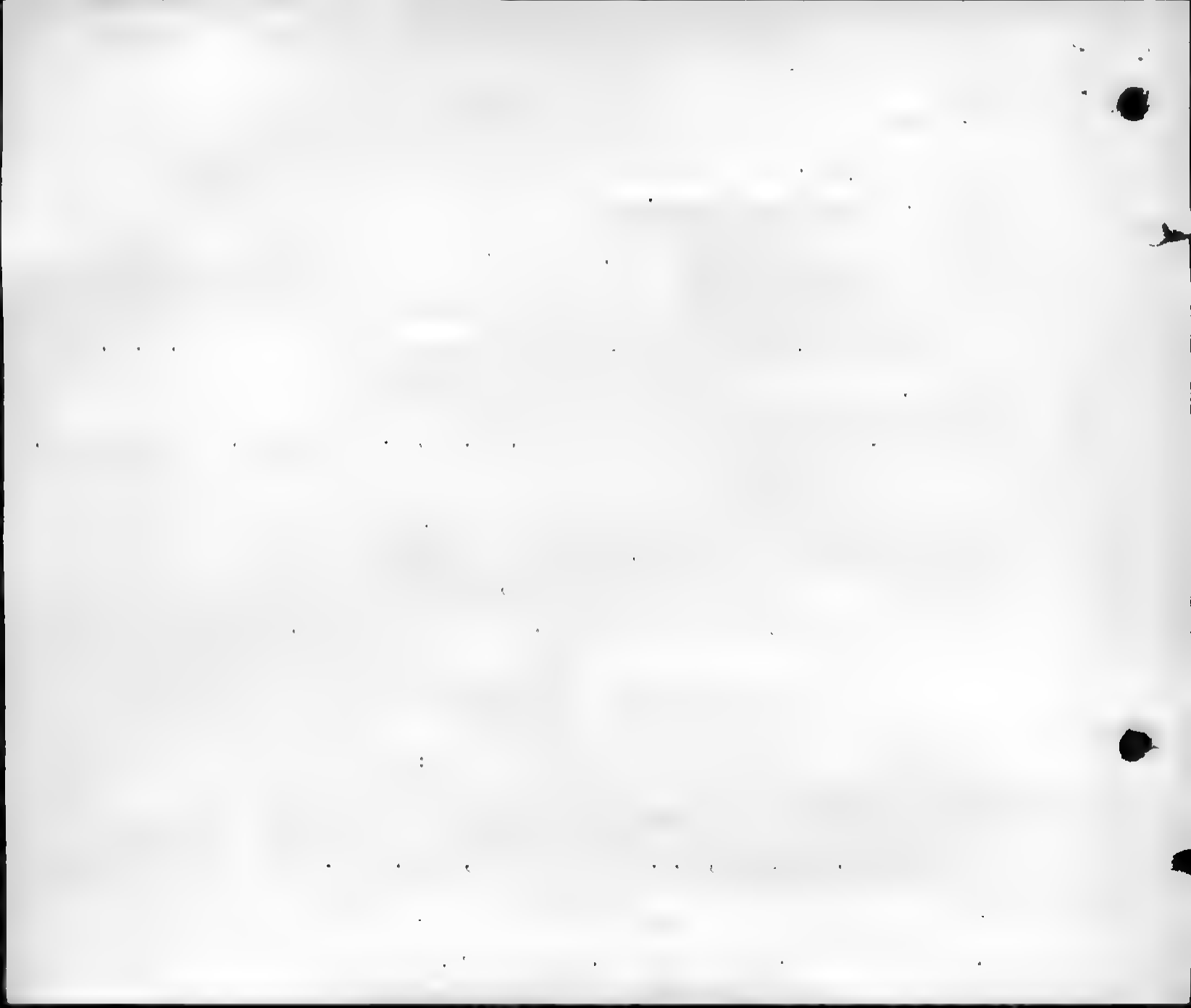
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08862

| | | | |
|---|--|--|--|
| 1 PLACE OF DEATH a COUNTY Baltimore b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md. c LENGTH OF STAY IN 1b 3 Days d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | 2 USUAL RESIDENCE (Where deceased lived) If inst. Res. Res. before admission) a STATE Maryland b COUNTY Baltimore c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (2) d STREET ADDRESS 623 Saint Paul Street e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First HARRY Middle H. Last McFARLAND | | 4 DATE OF DEATH Month August Day 18 Year 1960 | |
| 5 SEX Male 6 COLOR OR RACE White 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH November 22, 1895 9 AGE (In years last birthday) yrs 64 IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Erection Engineer 10b. KIND OF BUSINESS OR INDUSTRY Construction 11. BIRTHPLACE (State or foreign country) Atlanta, Georgia 12 CITIZEN OF WHAT COUNTRY? U. S. A. | | | |
| 13. FATHER'S NAME Edward H. McFarland 14 MOTHER'S MAIDEN NAME Agnes Ferrell | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I 16 SOCIAL SECURITY NO 257-05-1158 17. INFORMANT Clin. Rec. VAH, Baltimore 18, Md. FORT HOWARD DIV. Address | | | |
| 18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 420.0 BRONCHOPNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) PULMONARY CONGESTION AND EDEMA DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE EMPHYSEMA, BILATERAL, MARKED PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cortical Adenomata, adrenals, bilateral. Cerebral Congestion. | | INTERVAL BETWEEN ONSET AND DEATH RECENT RECENT UNKNOWN UNKNOWN 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <input type="checkbox"/> | | 20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f (City or town) (County) (State) | |
| 21 I certify that (I) (this hospital) attended the deceased from August 15, 1960 , to August 18, 1960 , that (I) (we) last saw the deceased alive on August 18, 1960 , and that death occurred at 3:20 P. M. from the causes and on the date stated above | | | |
| 22a SIGNATURE FREDERICK S. DONALDSON, M.D. 22c PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D. | | 22b DATE 8/19/60 22d ADDRESS VAH, BALTO, 18, MD, FORT HOWARD DIVISION | |
| 23a BURIAL, CREMATION REMOVAL (Specify) Burial 23b DATE THEREOF 8-22-60 23c NAME OF CEMETERY OR CREMATORY Baltimore National Cem. 23d LOCATION (City, town, or county) Baltimore, Maryland (State) | | 25a REC'D BY REGISTRAR Wm. Cook-Blight, Inc. 6009 Harford Rd., Balto. 14, Md. 25b REGISTRAR'S SIGNATURE Aug 24 '60 | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

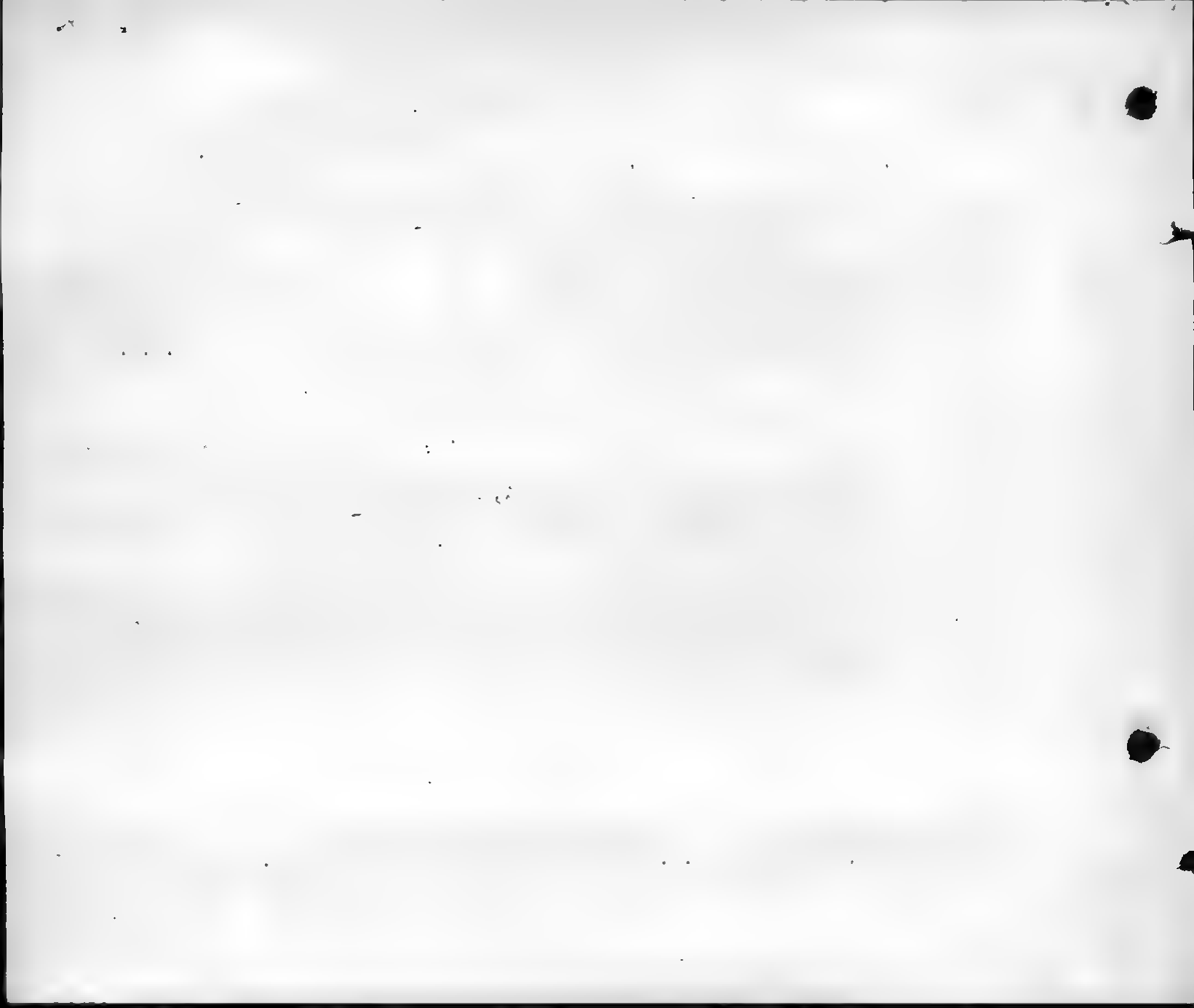
1 & 4

889

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08863

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland | | | | c. LENGTH OF STAY IN 1b 121 Days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | e. STREET ADDRESS 924 East Lombard Street | | | |
| 3. NAME OF DECEASED (Type or print) First CHARLES Middle ---- Last MC LAIN | | | | 4. DATE OF DEATH Month August Day 28 Year 1960 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH May 5, 1923 | |
| 9. AGE (In years lost birthday) 37 yrs | | F UNDER 1 YEAR Months Days Hours Min | | IF UNDER 24 HRS Months Days Hours Min | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Aide (Nurses) | | 10b. KIND OF BUSINESS OR INDUSTRY Hospital | | 11. BIRTHPLACE (State or foreign country) Dillon, S. Carolina | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William McLain | | | | 14. MOTHER'S MAIDEN NAME Catherine M. Barr | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes | | 16. SOCIAL SECURITY NO WW II 247-28-9370 | | 17. INFORMANT Clin. Rec. VAH, Baltimore 18, Md. FT. HOWARD DIVISION | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA, RIGHT FRONTAL LOBE OF BRAIN AND RIGHT ADRENAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) BRONCHOGENIC CARCINOMA (Clinical - Cured) (c) UNKNOWN DUE TO UNKNOWN | | | | | | | INTERVAL BETWEEN ONSET AND DEATH UNKNOWN |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 1. Pulmonary Congestion and Edema, recent 2. Pulmonary Emphysema, old. | | | | | | | 19. WAS AUTOPSY PERFORMED? NO |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (X) (this hospital) attended the deceased from April 29, 1960 to August 28, 1960 that (X) (we) last saw the deceased alive on August 28, 1960 and that death occurred at 9:25 PM M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Frederick S. Donaldson M.D. | | | | 22b. DATE 8/29/60 | | 22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D. | |
| 22d. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION | | | | 22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8/31/60 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem. | | 23d. LOCATION (City, town, or county) (State) Baltimore Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips, 1808 N. Monroe St. Balto. 17, | | | | 25a. REC'D BY REGISTRAR DATE SEP 1 '60 | | 25b. REGISTRAR'S SIGNATURE Clinton S. Kne... | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

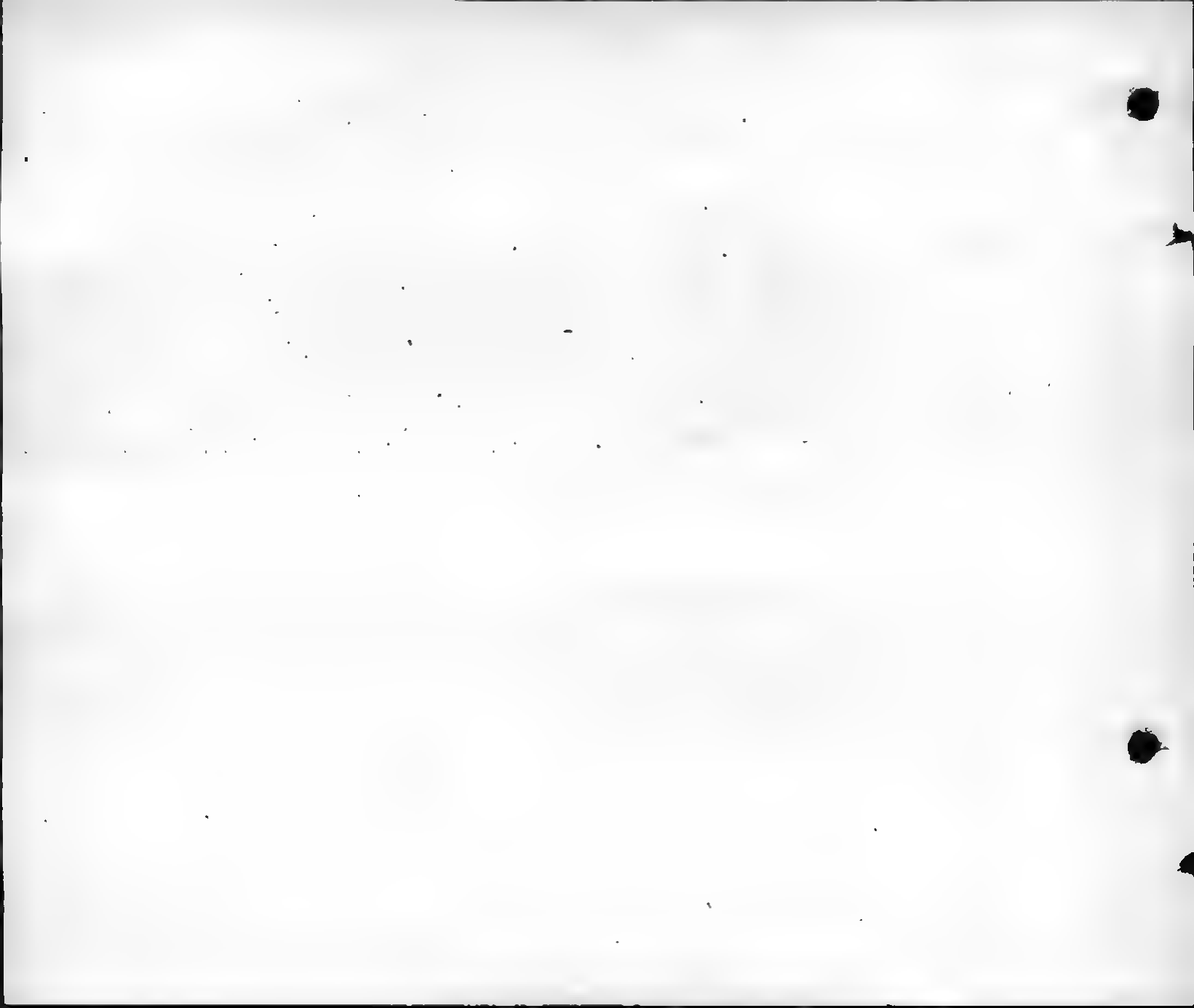
8892

CERTIFICATE OF DEATH

08864
Reg. Dist. No.

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>near Baltimore</u> | | c. LENGTH OF STAY IN 1b <u>20 min.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Key Highway</u> | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hereford - (Monkton R.D.)</u> | |
| f. STREET ADDRESS <u>1 Monkton Rd.</u> | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Raymond M. Miller</u> | | 4. DATE OF DEATH Month <u>Aug</u> Day <u>19</u> Year <u>1960</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 2, 1899</u> |
| 9. AGE (In years last birthday) <u>61</u> yrs | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Fabricating Steel</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Monkton, Md. R.D.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>S. Howard Miller</u> | | 14. MOTHER'S MAIDEN NAME <u>Tempie Mays</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown <input type="checkbox"/> If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO <u>206-01-2388</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) _____ | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>1950</u> to <u>Aug 19, 1960</u> , that I last saw the deceased alive on <u>Aug 1, 1960</u> , and that death occurred at <u>8:10 AM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>A. M. France</u> M.D. | | ADDRESS (Street, city or town, state) <u>P. R. K. TOIV, MD.</u> | |
| PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u> | | DATE SIGNED <u>8/19/60</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>Aug 22, 1960</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Fosters Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Monkton, Md. R.D.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Fortenberry, New Freedom, Pa.</u> | | 24a. REC'D BY REGISTRAR <u>AUG 23 '60</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8893

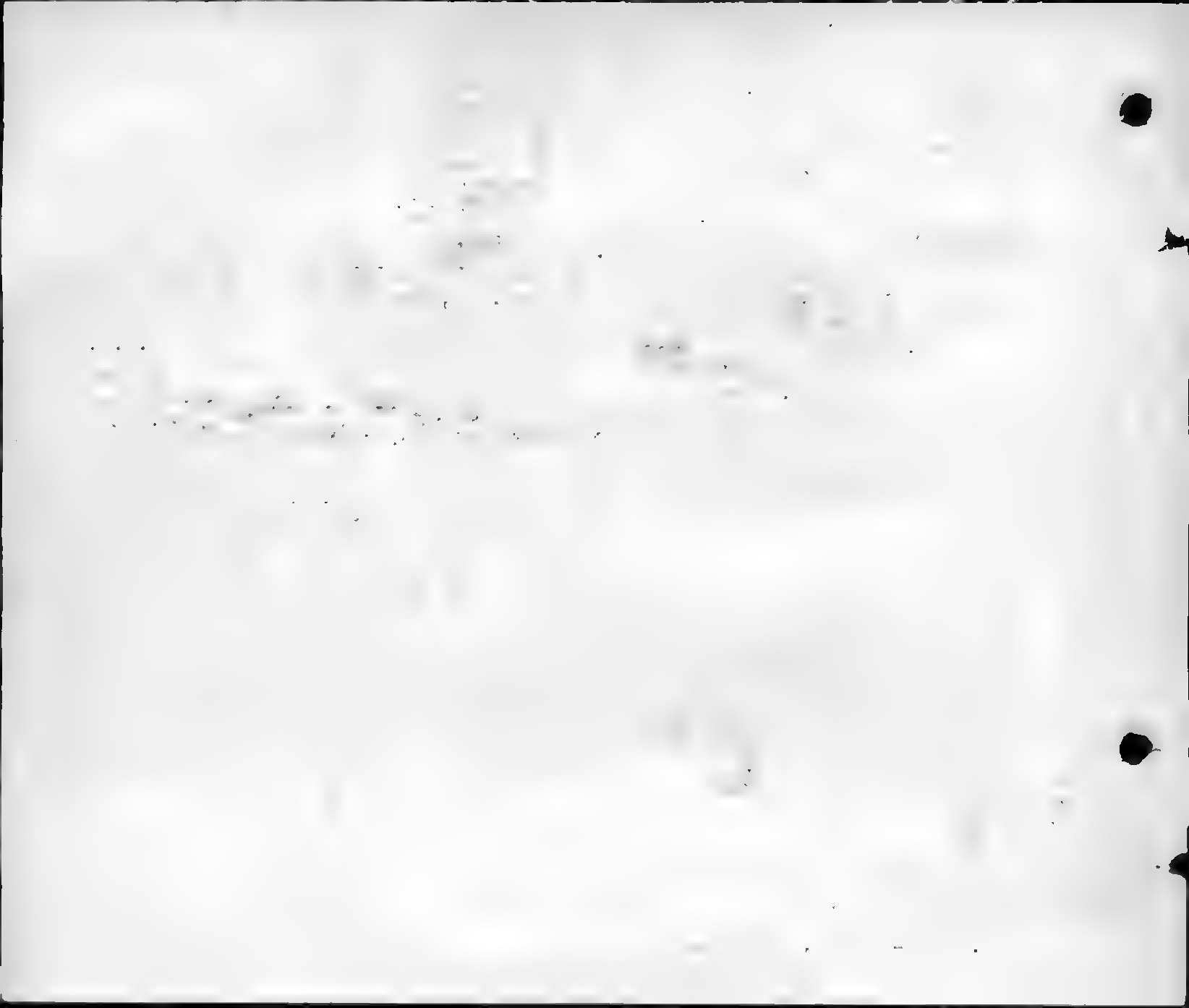
CERTIFICATE OF DEATH

Reg. Dist. No. 08865

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) o. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 31 1-4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Forest Haven Nursing Home | | d. STREET ADDRESS 5307 Barbara Avenue • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Eliza Middle M. Last Mitchell | | 4. DATE OF DEATH Month August Day 5 Year 19 60 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 12, 1875 |
| 9. AGE (In years last birthday) yrs 84 | | IF UNDER 1 YEAR: Months 5 Days 19 Hours 60 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) West Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William Covell | | 14. MOTHER'S MAIDEN NAME unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Duncan Miller, 4511 Mainfield Avenue | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO-SCLEROTIC CARDIO - 350X DUE TO UNUSUAL DISEASE - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO-SCLEROTIC DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 1/1 1960, to 8/5 1960, that I last saw the deceased alive on 8/4 1960, and that death occurred at 4:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE John H. Shaw M.D. | | DATE SIGNED 8/6/60 | |
| PHYSICIAN'S NAME (Type) John H. Shaw M.D. | | DATE SIGNED BALTIMORE, MD. | |
| 22a. BURIAL, CREMATION, or other disposal (Specify) BURIAL | 22b. DATE THEREOF 8-8-60 | 22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial | 22d. LOCATION (City, town, or county) (State) Baltimore |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, 6609 Harford Road | | 24a. REC'D BY REGISTRAR DATE AUG 8 '60 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08866

15000

8894

| | | | |
|---|----------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY 1 | |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) CATONSVILLE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3 SANFORD AVE | | d. STREET ADDRESS 3 SANFORD AVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) NELLIE B. MURPHY | | 4. DATE OF DEATH AUG. 3, 1960 | |
| 5. SEX F. | 6. COLOR OR RACE W. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH DEC. 24/1881 |
| 9. AGE (In years) 78 yrs | | 10. IF UNDER 1 YEAR: Months 3 Days 3 Hours 19 Min 60 | |
| 10a. USLA. OCCUPATION (Give kind of work done during most of working life, even if retired) H.W. | | 10b. KIND OF BUSINESS OR INDUSTRY O.H. | |
| 11. BIRTHPLACE (State or foreign country) MD. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JAMES S. BENSON | | 14. MOTHER'S MAIDEN NAME MARY JANE ALLNUTT | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO | |
| 17. INFORMANT MR. HARRY T. MURPHY | | 18. ADDRESS 6207 HOOKS LANE BALTO. 27, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS GENERALIZED DUE TO 1 Conditions "if any" which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA (c) STOMACH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 YR | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II of item 18) This ok'd by Med. Examiner | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) | | 20f. (City or town) Baltimore (County) MD. (State) MD. | |
| 21. I certify that (I) (this hospital) attended the deceased from July 1, 1940 to Aug. 3, 1960 , that (I) (we) last saw the deceased alive on July 29, 1960 , and that death occurred at 8 A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE A. H. CROWTHER JOHN F. SCHAEFER | | 22b. DATE SIGNED 8/5/60 | |
| 22c. PHYSICIAN'S NAME (Type) John F. Schaefer MD | | 22d. ADDRESS 401 RANDOM ROAD - 29 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 8/6/60 | |
| 23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET | | 23d. LOCATION (City, town, or county) (State) FREDERICK, MD. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE WITKE FUN. DIR. | | 25a. REC'D BY REGISTRAR 4101 EDMONDSON | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas | | 25c. DATE AUG 8 '60 | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8895

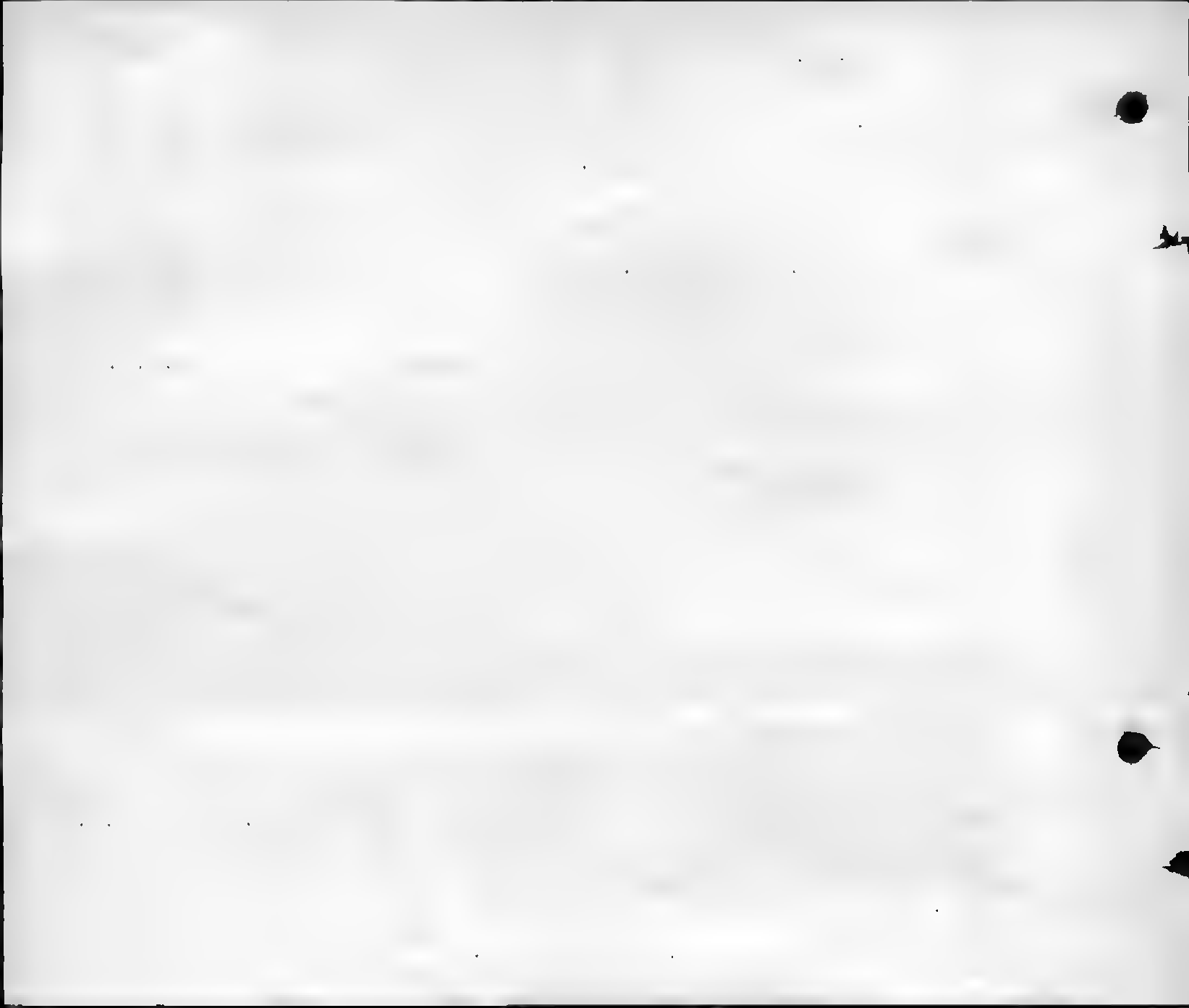
CERTIFICATE OF DEATH

08867

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale | | c. LENGTH OF STAY IN 1b 6 Months | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1330 Seling Avenue | | e. STREET ADDRESS 1330 SELING AVENUE | |
| 3. NAME OF DECEASED (Type or print) DAVID W. NARANGO SR. | | 4. DATE OF DEATH Month AUGUST Day 3 Year 1960 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 25, 1890 |
| 9. AGE (In years last birthday) 70 yrs | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | |
| 11. BIRTHPLACE (State or foreign country) Cuba | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13. FATHER'S NAME Antonio Narango | | 14. MOTHER'S MAIDEN NAME Anita Mandosa | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. Mrs Marie Narango 1330 Seling Avenue | |
| 17. INFORMANT Mrs Marie Narango 1330 Seling Avenue | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma sigmoid 1553 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 1 yr | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 15 Sept. 1959 to 3 Aug. 1960 , that I last saw the deceased alive on 3rd Aug. 1960 , and that death occurred at 2:30 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) 104 W. Madison St. DATE SIGNED Aug. 3. 60 | | | |
| ACTUAL SIGNATURE S.E. Proctor (u) M.D. | | PHYSICIAN'S NAME (Type) S.E. Proctor | |
| 22a. BURIAL, CREMAT. ON, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/6/60 | |
| 22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery | | 22d. LOCATION (City, town, or county) (State) Baltimore Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC. BALTIMORE MD. | | 24a. REC'D BY REGISTRAR AUG 4 '60 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Frank | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

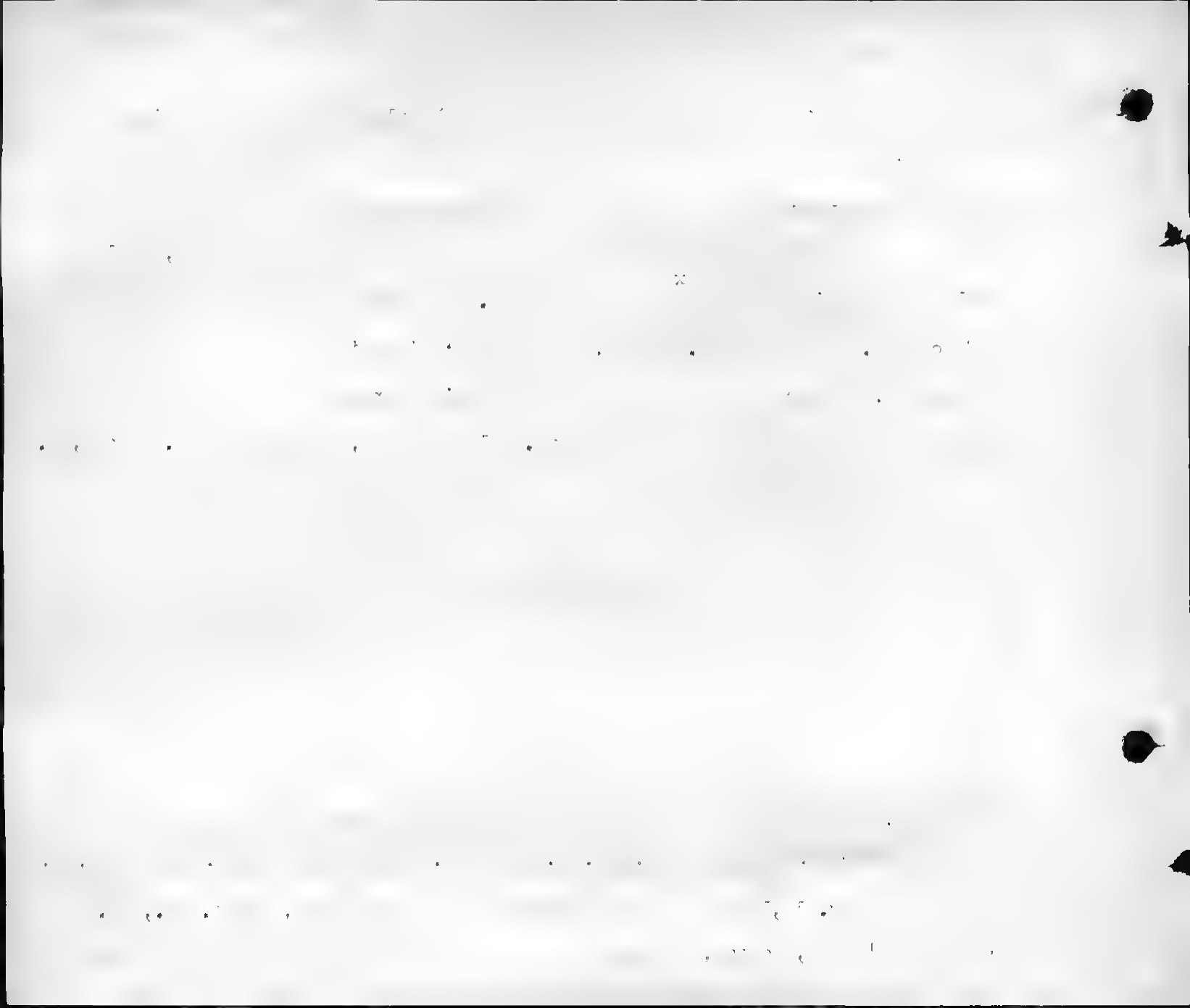
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TSM 9/59

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1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08868

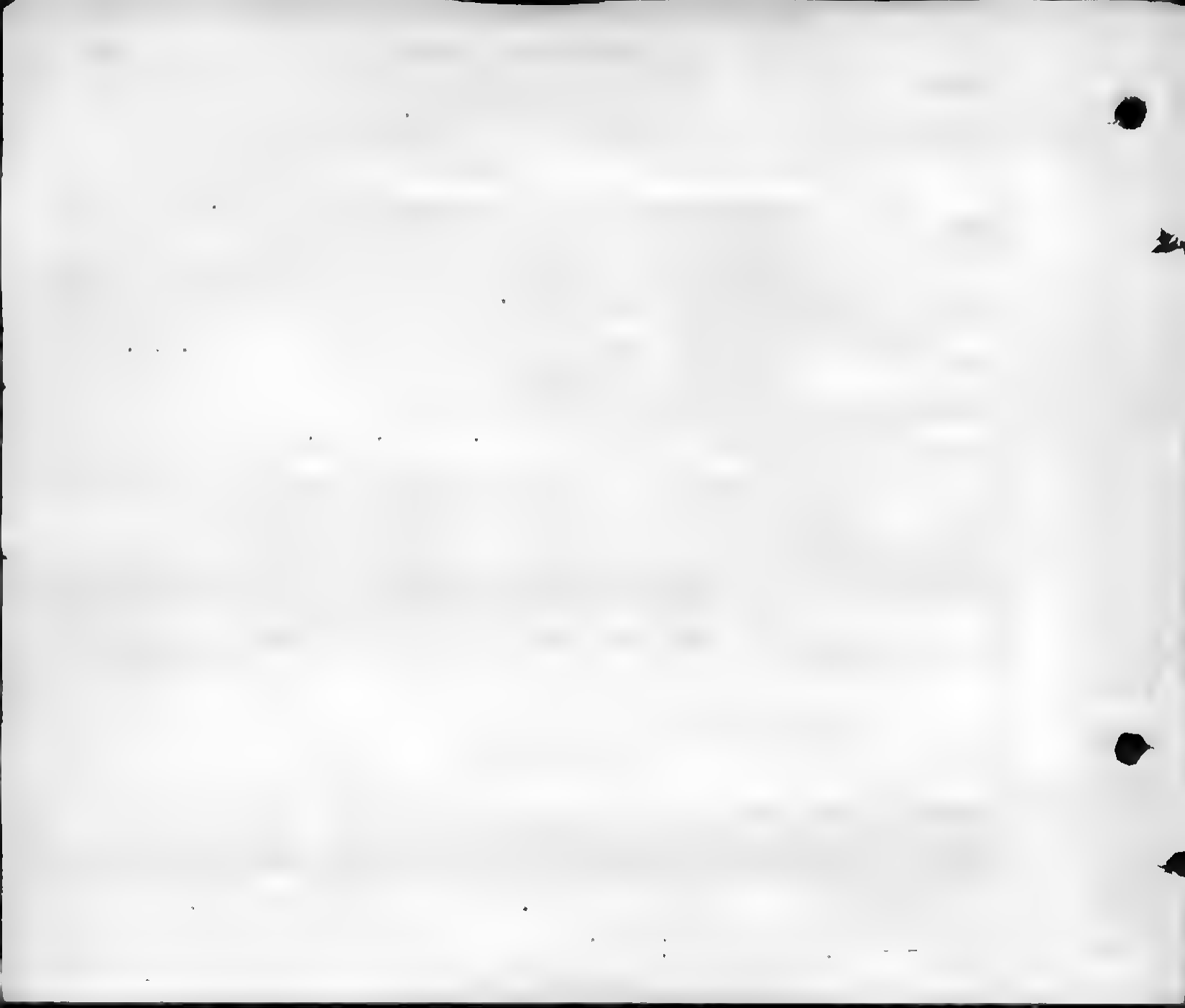
| | | | | | | | |
|--|----------------------------------|---|---|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | | | c. LENGTH OF STAY IN TB | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9 Maryland Avenue | | | | e. STREET ADDRESS 9 Maryland Avenue | | | |
| 3. NAME OF DECEASED (Type or print) First CLARENCE Middle EMORY Last NETHKEN | | | | 4. DATE OF DEATH Month August Day 14 Year 1960 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 25, 1909 | 9. AGE (In years last birthday) yrs 50 | IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0 | IF UNDER 24 HRS Hours 0 Min 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Mgr. | | 10b. KIND OF BUSINESS OR INDUSTRY Gen. Can Co. | | 11. BIRTHPLACE (State or foreign country) West Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Steward B. Nethken | | | | 14. MOTHER'S MAIDEN NAME Addie Fuhrman | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. WW II | | 17. INFORMANT Mrs. Helen Nethken, 9 Maryland Ave., Towson, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) adenocarcinoma, rt. lung, & cerebral metastasis 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 16 mos |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Apr. 27, 1960 to August 14, 1960 , that (I) (we) last saw the deceased alive on Aug. 13, 1960 , and that death occurred at 2:15 AM, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Roy W. Chesnut, Jr. | | | | 22b. DATE SIGNED Aug 19 1960 | | 22c. PHYSICIAN'S NAME (Type) Roy W. Chesnut, Jr., M. D. | |
| 22d. ADDRESS 25 W. Pennsylvania Ave., Towson 4, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Aug. 17, 1960 | | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | | 23d. LOCATION (City, town, or county) (State) Woodlawn, Balto. Co., Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland | | | | 25a. REC'D BY REG. STRAR DATE AUG 19 1960 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Hines | |



Reg. Dist. No. 08869

| | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | BALTIMORE | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE | | Md. | | b. COUNTY | | BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | ROSEDALE | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | X ROSEDALE | | d. STREET ADDRESS | | 6507 KENWOOD AVE. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | 6507 KENWOOD AVENUE #6 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 3. NAME OF DECEASED (Type or print) | | First | | Middle | | Last | |
| BARBARA | | NOREK | | 4. DATE OF DEATH | | August 4 | | Day | | Year | | 19 60 | |
| 5. SEX | | female | | 6. COLOR OR RACE | | white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH | | Dec. 4, 1881 | |
| 9. AGE (In years last birthday) | | 78 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | housewife | | 11. BIRTHPLACE (State or foreign country) | | Czechoslovakia | | 12. CITIZEN OF WHAT COUNTRY? | |
| U.S.A. | | 13. FATHER'S NAME | | Bones | | 14. MOTHER'S MAIDEN NAME | | unknown | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT | | Jerry W. Norek, son, above | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY OCCLUSION & MYOCARDIAL INFARCT | | INTERVAL BETWEEN ONSET AND DEATH | | AUG 4/60 | | SEPT 1 1960 | |
| DUE TO | | (b) ARTERIOSCLEROTIC C.V. DISEASE | | DUE TO | | (c) HYPERTENSION | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | NONE | | 20c. TIME OF INJURY Month, Day, Year | | 20d. INJURY OCCURRED | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| NONE 19 | | While <input type="checkbox"/> On <input checked="" type="checkbox"/> At work | | NONE | | NONE | | NONE | | NONE | | NONE | |
| 21. I certify that I attended the deceased from 9-1-59 to 8-4-60, that I last saw the deceased alive on 8-4-60, 12 P.M., and that death occurred at 2 P.M., from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) | | DATE SIGNED | | E. G. SCHIMUNEK M.D. | | 8425 EAST AVE BALTO. 24 MD | | 8-5-60 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | Burial | | 22b. DATE THEREOF | | 8/8/60 | | 22c. NAME OF CEMETERY OR CREMATORY | | Moreland Mem. Park | | 22d. LOCATION (City, town, or county) (State) | |
| Baltimore, Md. | | 23. FUNERAL DIRECTOR'S SIGNATURE | | Schimunek Funeral Home, Inc. | | 24a. REC'D BY REGISTRAR | | DATE | | AUG 8 '60 | | 24b. REGISTRAR'S SIGNATURE | |
| 2601-3-5 E. Madison St. | | C. H. K. K. | | | | | | | | | | | |

VS A15 (4)
15M 9/55



1
STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

88870

1. PLACE OF DEATH
a. COUNTY **Baltimore** MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Kingsville**

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) **510 Stony bottom Road**

2. USUAL RESIDENCE (Where deceased lived, if institut on, Res dnce before adm ss on)
a. STATE **Maryland** b. COUNTY **Baltimore**

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Kingsville**

d. STREET ADDRESS **510 Stonybottom Road**

3. NAME OF DECEASED (Type or print) **MELVIN GEORGE OREM**

4. DATE OF DEATH **8/8/60**

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH **May 6, 1904**

9. AGE (In years, if UNDER 1 YEAR, IF UNDER 24 HRS last birthday) **56** yrs Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Laborer**

10b. KIND OF BUSINESS OR INDUSTRY **Gas & Elec. Co.**

11. BIRTHPLACE (State or foreign country) **Balto. Co. Md.**

12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **George N. Orem**

14. MOTHER'S MAIDEN NAME **Amsey Ellen**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No** (If yes give year or dates of service)

16. SOCIAL SECURITY NO. **212-05-5972**

17. INFORMANT **Mrs. Elsie Folks** Address **510 Stoney Batter Rd.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) **Gunshot wound of chest**
DUE TO
Conditions, any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.
20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING CAUSE OF DEATH. **Gunshot wound of chest**
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month Day Year **8/8/1960** 20d. INJURY OCCURRED While ☐ Not While ☒ at work ☐ outside home
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **Kingsville, Baltimore, Md.**
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

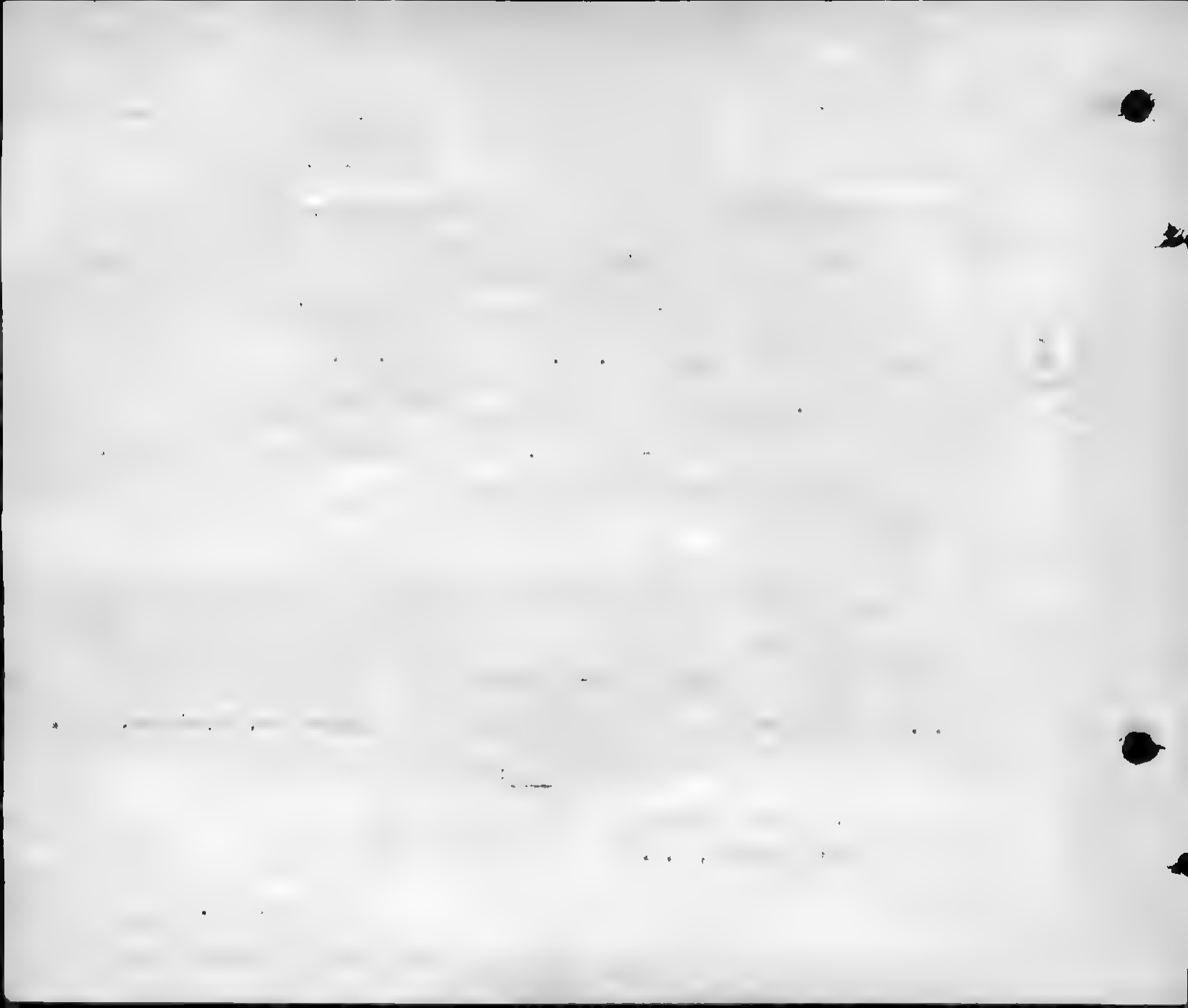
ACTUAL SIGNATURE **Peter Rieckert** M.D. CHIEF MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type) **Peter Rieckert, M.D.** ASSISTANT MEDICAL EXAMINER ☒

DEPUTY MEDICAL EXAMINER ☐ DATE SIGNED **8/8/60**

22a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 22b. DATE THEREOF **8-11-1960** 22c. NAME OF CEMETERY OR CREMATORY **Belair Memorial Gardens** 22d. LOCATION (City, town, or country) (State) **Belair, Md.**

23. FUNERAL DIRECTOR **Lassahn Funeral Home** ADDRESS **7401 Belair Road** 24a. REC'D BY REGISTRAR **AUG 10 '60** 24b. REGISTRAR'S SIGNATURE **Arthur S. Kraus**



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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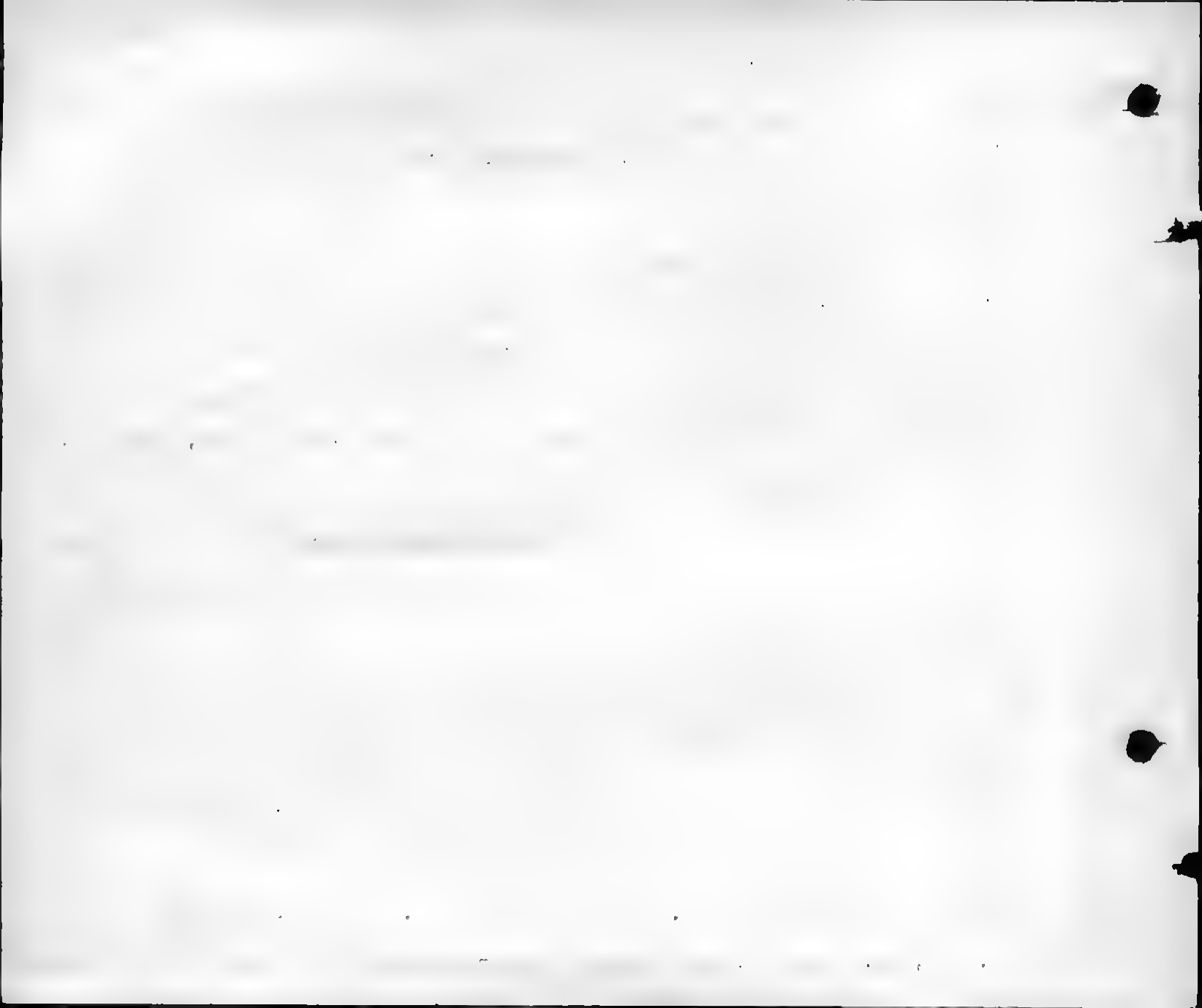
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|--|--|
| 1 PLACE OF DEATH COUNTY <u>Baltimore</u> <u>Agd Men + Agd women Home</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Md</u> COUNTY <u>Baltimore</u> | |
| a. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson md.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>615 Chestnut ave.</u> | | d. STREET ADDRESS <u>1802 Walbrook Ave.</u> <u>REWEGE</u> | |
| 3 NAME OF DECEASED (Type or print) First <u>dda</u> Middle <u>Jamie</u> Last <u>Paca</u> | | 4. DATE OF DEATH Month <u>8</u> Day <u>15</u> Year <u>1960</u> | |
| 5 SEX <u>F</u> | 6. COLOR OR RACE <u>W.</u> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>Feb. 6, 1871</u> |
| 9 AGE (In years last birthday) <u>89</u> yrs | | 10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>9</u> IF UNDER 24 HRS: Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dress maker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Harford Co - Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>George Kuelhinger</u> | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Bush</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>none</u> | | 16 SOCIAL SECURITY NO. <u>none</u> | |
| INFORMANT Address <u>Agd Men's & Agd Women's Home, Towson 4, Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, Bronchial</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>3 years</u> |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>1958</u> to <u>August 15, 1960</u> , that I last saw the deceased alive on <u>August 13, 1960</u> , and that death occurred at <u>9:45 PM</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <u>Newland Edward Day M.D. 4-E-331 St - Balto 18 Wd Aug 15, 1960</u> | | | |
| ACTUAL SIGNATURE <u>Newland Edward Day M.D.</u> | | PHYSICIAN'S NAME (Type) <u>Newland Edward Day M.D.</u> | |
| 22a. BURIAL CREMATION, etc. (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>8-19-60</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Christian Church Cem.</u> | 22d. LOCATION (City, town, or county) (State) <u>Belair, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street, Baltimore</u> | | 24a. REC'D BY REGISTRAR DATE <u>AUG 18 '60</u> | 24b. REGISTRAR'S SIGNATURE <u>Clifton S. Fries</u> |

(M)

(I)



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, write the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

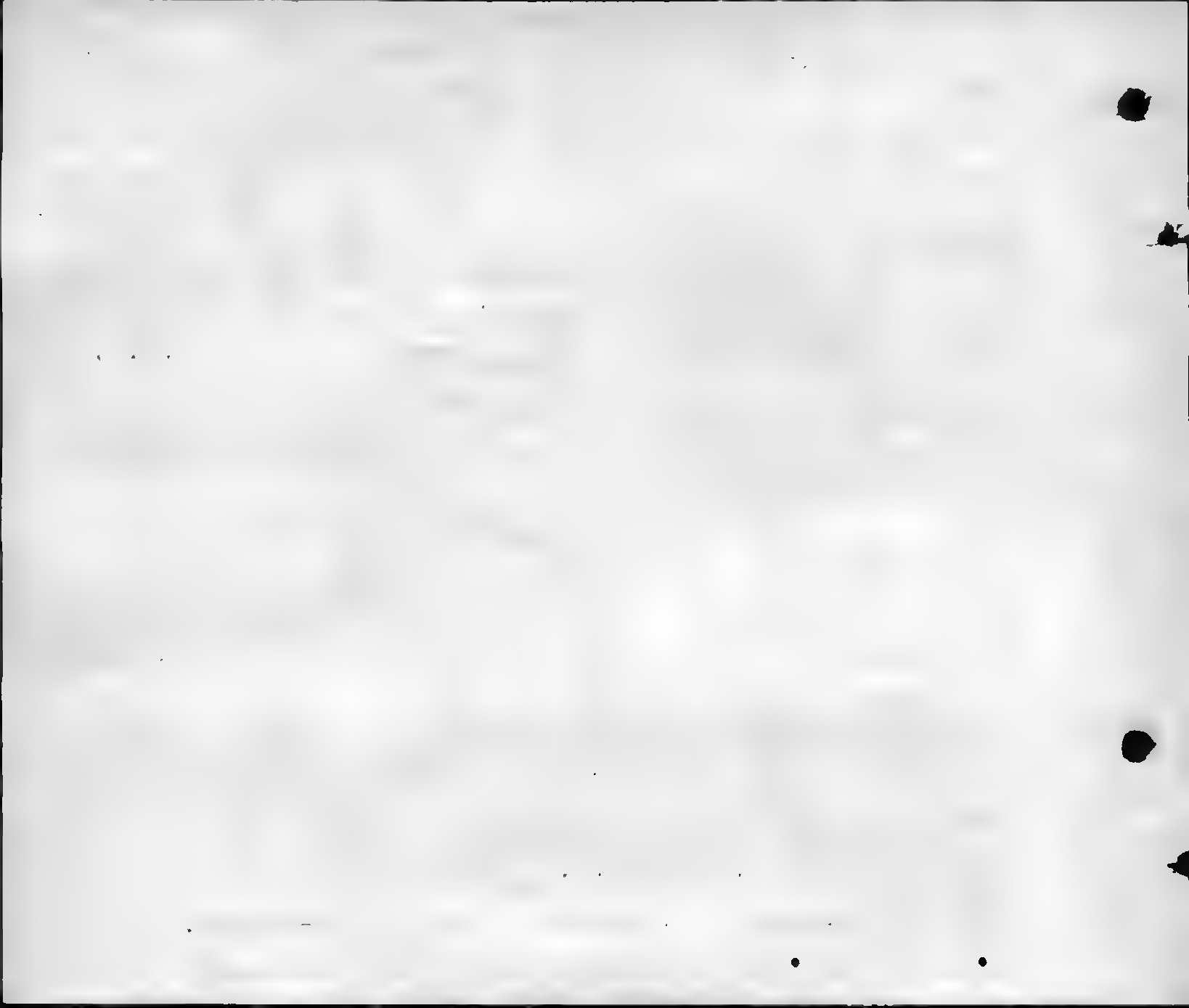
8900

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08872

| | | | | | | | |
|---|----------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 6mth 2days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis, Maryland | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL | | | | d. STREET ADDRESS 402 Washington Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Elizabeth Middle Parkin Last Parkin | | | | 4. DATE OF DEATH Month 8 Day 3 Year 1960 | | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 5, 1867 | | 9. AGE (In years last birthday) 92 yrs. | IF UNDER 1 YEAR Months 2 Days 3 | IF UNDER 24 HRS Hours 3 Min. 19 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY own home | | 11. BIRTHPLACE (State or foreign country) Ohio | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Thomas Emile | | | | 14. MOTHER'S MAIDEN NAME Sara | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Sub-trochanter fracture left from accident PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Right femur was pinned at the University Hospital on 6-30-60 | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) fell to floor and sustained an intertrochanteric frac. of rt. | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour 12:45 P. M. 6-27 1960 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital | | 20f. (City or town) (County) Catonsville 28, Maryland (State) femur | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <i>George M. Kieffer</i> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) George M. Kieffer, M. D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Aug. 6, 1960 | | 22c. NAME OF CEMETERY OR CREMATORY Mt. Greenwood Cemetery | | 22d. LOCATION (City, town, or county) (State) Annapolis, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Hopping Funeral Home</i> | | | | ADDRESS Annapolis, Maryland | | 24a. REC'D BY REGISTRAR DATE AUG 8 '60 | |
| | | | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraw</i> | | DATE SIGNED Aug. 4, 60 | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The attending physician or attending physician may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

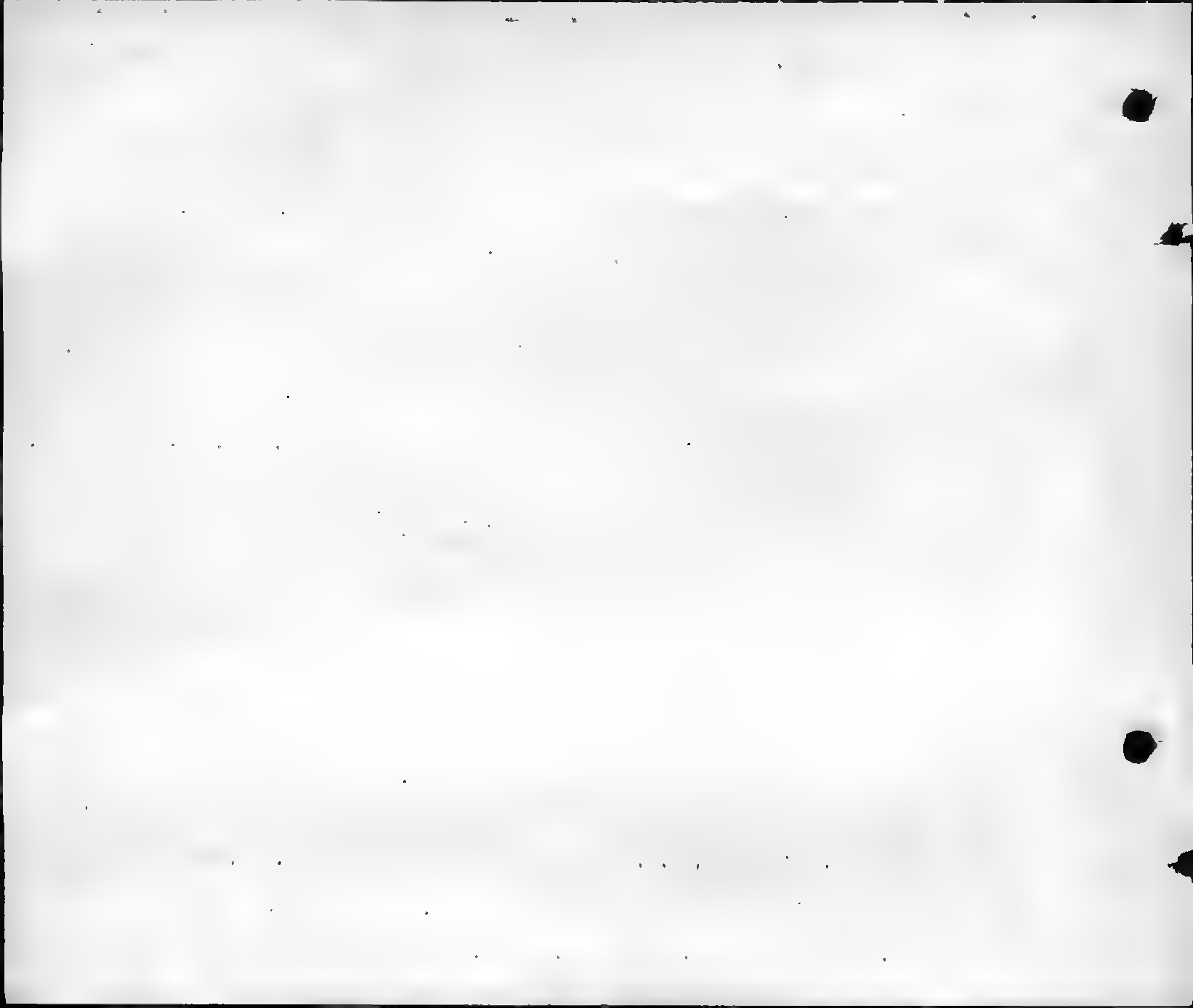
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8901

CERTIFICATE OF DEATH

08873

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> | | c. LENGTH OF STAY IN 1b <u>3 days</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u> | | d. STREET ADDRESS <u>1816 Pennsylvania Avenue</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>E.</u> Last <u>PENDLETON</u> | | 4. DATE OF DEATH Month <u>August</u> Day <u>15</u> Year <u>1960</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>August 24, 1908</u> |
| 9. AGE (In years last birthday) <u>51</u> yrs | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | 11. IF UNDER 24 HRS. Hours <u> </u> Min <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Road Construction</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Charleston, West Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Charles Pendleton</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary (Maiden Name Unknown)</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u> | | 16. SOCIAL SECURITY NO <u>199-05-9564</u> | |
| 17. INFORMANT <u>Clinical Records, Vet. Adm. Hosp. Ft. Howard Div.</u> | | Address <u>Baltimore, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> DUE TO <u>BRONCHOGENIC CARCINOMA, RIGHT LUNG</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>ENCEPHALOMALACIA, RIGHT CEREBRUM</u> (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> (c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH <u>Recent</u> <u>Unknown</u> <u>Unknown</u> <u>Unknown</u> | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (X) (this hospital) attended the deceased from <u>August 12, 1960</u> to <u>August 15, 1960</u> , that (X) (we) last saw the deceased alive on <u>August 15, 1960</u> , and that death occurred at <u>P. M.</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>FREDERICK S. DONALDSON, M.D.</u> | | 22b. ADDRESS <u>VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION</u> | |
| 22c. PHYSICIAN'S NAME (Typed) <u>FREDERICK S. DONALDSON, M.D.</u> | | 22d. DATE <u>8/16/60</u> | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>8/18/60</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u> | | 23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Arlington S. Phillips, 1808 N. Monroe St., Balto. 17</u> | | 25a. REC'D BY REGISTRAR <u>DATE AUG 19 '60</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u> | | 25c. REGISTRAR'S SIGNATURE <u> </u> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8902

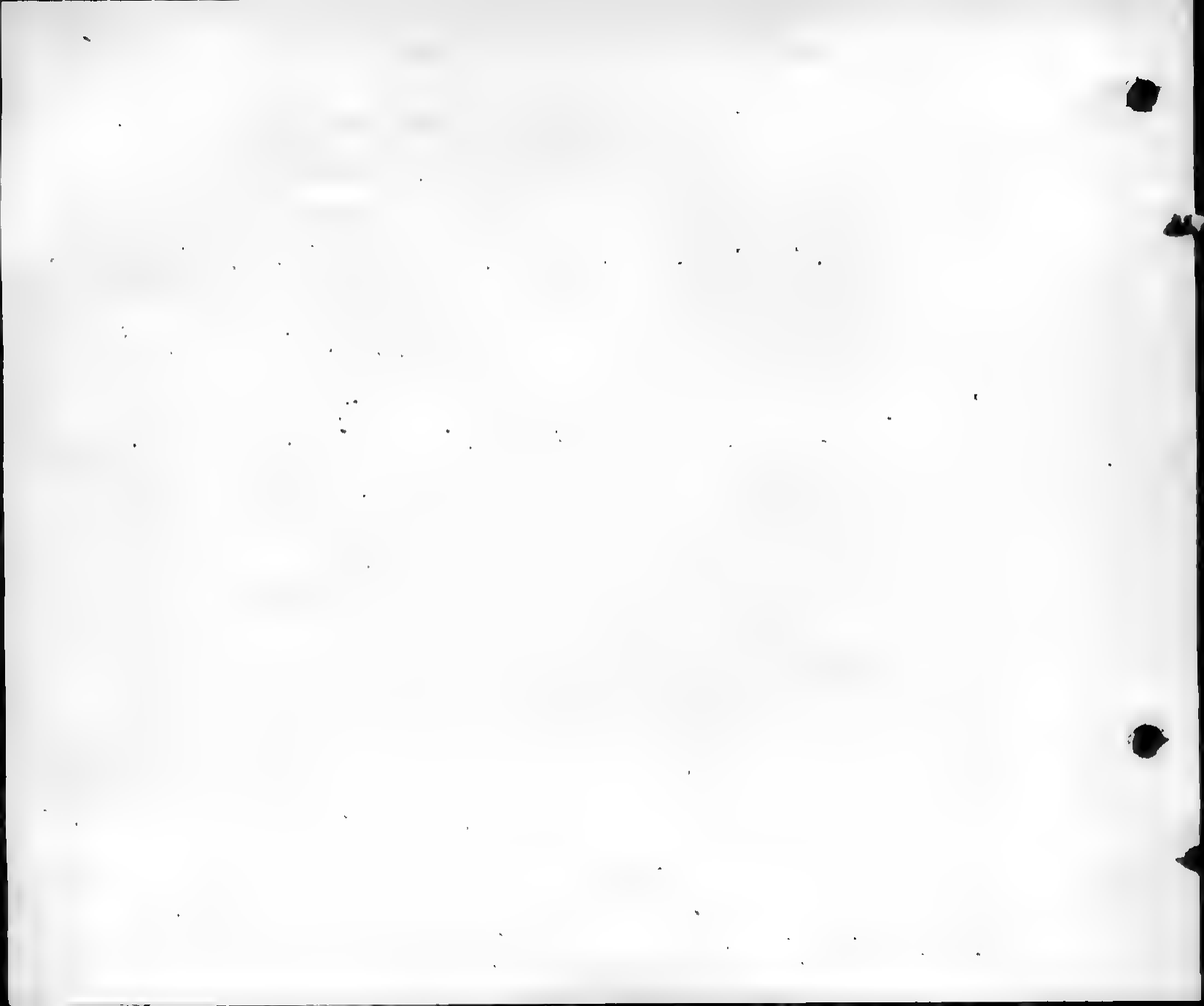
CERTIFICATE OF DEATH

Reg. Dist No. 08874

| | | | |
|---|--------------------------|---|---|
| 1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived if institution, residence, before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u> | |
| c. LENGTH OF STAY IN 1b <u>40 yrs.</u> | | d. STREET ADDRESS <u>Mt. Carmel Rd.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Carmel Rd.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) <u>W. Russell Peregoy</u> | | 4. DATE OF DEATH <u>August 21</u> 19 <u>60</u> | |
| 5 SEX <u>M</u> | 6 COLOR OR RACE <u>W</u> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>March 19 1920</u> <u>Pa.</u> |
| 9. AGE (In years last birthday) <u>40</u> yrs | | IF UNDER 1 YEAR IF UNDER 24 HRS | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Parkton, Md.R.D.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>George Peregoy</u> | | 14. MOTHER'S MAIDEN NAME <u>Laura Zencker</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>218-18-0696</u> | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> | | | |
| DUE TO (b) <u>Myocardial stenosis</u> | | | |
| DUE TO (c) <u>Rheumatic heart disease</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>June</u> 19 <u>60</u> , to <u>August 21</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>August 20</u> , 19 <u>60</u> , and that death occurred at <u>10:15 PM</u> , from the causes and on the date stated above | | | |
| ACTUAL SIGNATURE <u>C. Herbert Mueller Jr</u> M.D. | | ADDRESS (Street, city or town, state) <u>YORK RD. HEREFORD-PARKTON, PA.</u> | |
| PHYSICIAN'S NAME (Type) <u>C. HERBERT MUELLER JR</u> | | DATE SIGNED <u>8-22-60</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Aug 24 1960</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u> | | 22d. LOCATION (City or town, or county) (State) <u>Parkton, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein</u> ADDRESS <u>New Freedom, Pa.</u> | | 24a. REC'D BY REGISTRAR DATE <u>AUG 25 '60</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>T. L. & H. H.</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| 1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Relay</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11004 Frances Ave.</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Ft. Ho.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Relay</u> d. STREET ADDRESS <u>11004 Frances Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Katherine B. Pfaff</u> First Middle Last | | 4. DATE OF DEATH <u>Aug. 18</u> 19 <u>60</u> Month Day Year | |
| 5. SEX <u>Female</u> 6. COLOR OR RACE <u>W.</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan. 1, 1884</u> 9. AGE (In years last birthday) <u>76</u> yrs 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> 11. BIRTHPLACE (State or foreign country) <u>Barto. Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>Joseph Kaufmann</u> 14. MOTHER'S MAIDEN NAME <u>Katie</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> 16. SOCIAL SECURITY NO <u>Wm. S. Pfaff</u> 17. INFORMANT <u>1004 Frances Ave</u> Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Breast Metastatic</u> (b) <u>Carcinoma of Rt. Breast</u> (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (a): PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Metastatic - carcinoma to spine</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May 8</u> 19 <u>59</u> to <u>Aug. 18</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Aug. 17</u> 19 <u>60</u> , and that death occurred on <u>Aug. 18</u> 19 <u>60</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>A. Bradley Saughasch</u> 22c. PHYSICIAN'S NAME (Type) | | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22d. ADDRESS 22b. DATE SIGNED <u>8-18-60</u> | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial Aug. 22/60</u> 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u> 23d. LOCATION (City, town or county) (State) <u>A. A. Co. Md.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Wigle</u> ADDRESS <u>4101 Edmondson Ave</u> | | 25a. REC'D BY REGISTRAR DATE <u>AUG 22 '60</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9.59

8903

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08876

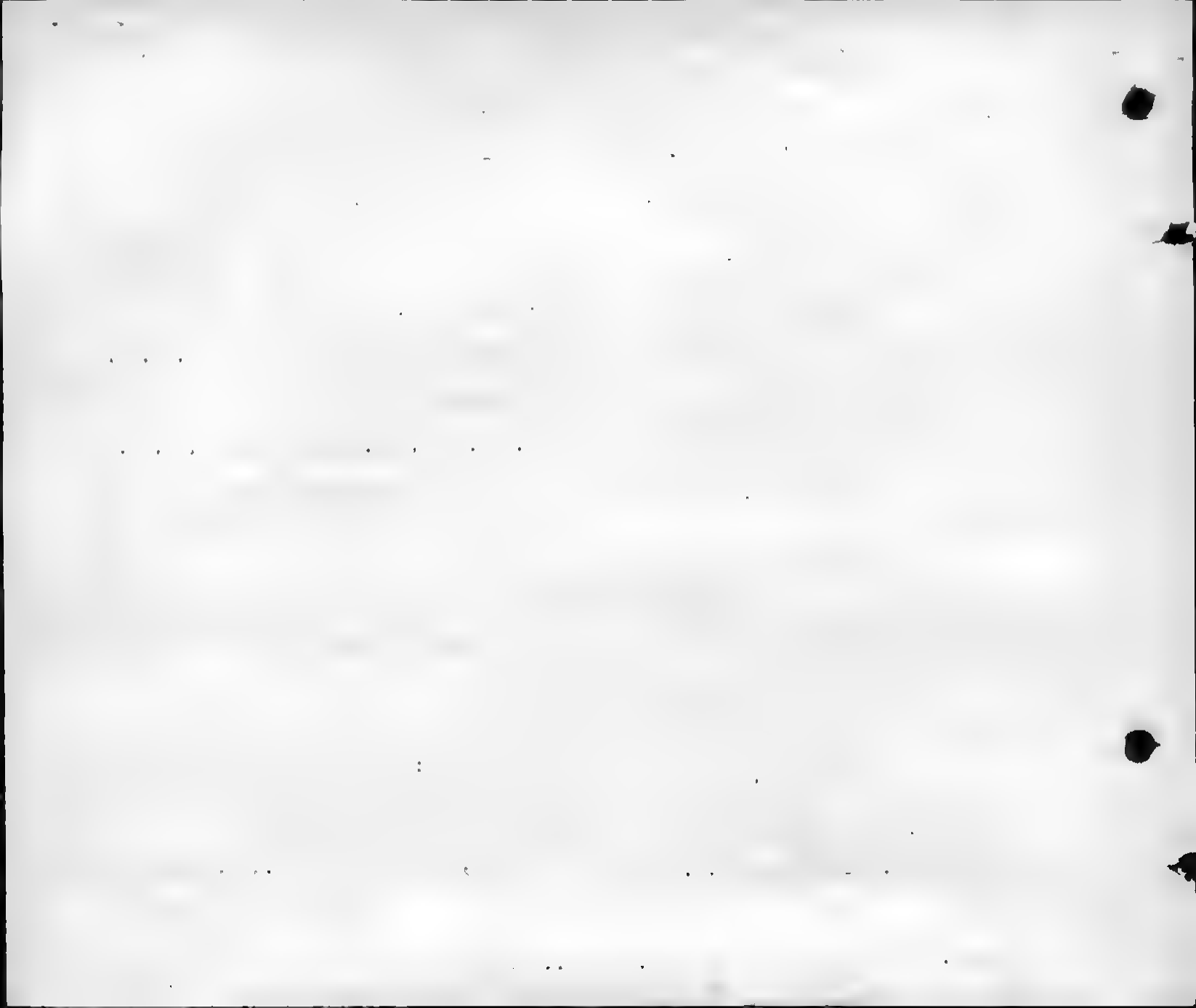
| | | | |
|---|---------------------------------|--|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | 2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| c. LENGTH OF STAY IN 1b 125 Days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | d. STREET ADDRESS 400 South Macon Street (24) | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3 NAME OF DECEASED (Type or print) First Middle Last SOTIRIOS --- PLAKITSIS | | 4. DATE OF DEATH Month Day Year August 2 1960 | |
| 5 SEX Male | 6 COLOR OR RACE White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH September 15, 1890 |
| 9. AGE (in years last birthday) 69 yrs | | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner | | 10b. KIND OF BUSINESS OR INDUSTRY Coal | |
| 11. BIRTHPLACE (State or foreign country) Greece | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME John Plakitsis | | 14. MOTHER'S MAIDEN NAME Katherine Pavouris | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes | | 16. SOCIAL SECURITY NO. 212-36-1034 | |
| 17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Balto. Md. Ft. Howard | | Address Division Balto. Md. Ft. Howard | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA WITH WIDESPREAD METASTASES DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC LYMPHATIC LEUKEMIA 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home farm factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (he) (this hospital) attended the deceased from March 30, 1960 to August 2, 1960 , that (he) (we) last saw the deceased alive on Aug. 2, 1960 , and that death occurred at 10:45 P. M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Walter J. Pijanowski | | 22b. DATE SIGNED 8/3/60 | |
| 22c. PHYSICIAN'S NAME (Type) WALTER J. PIJANOWSKI, M.D. | | 22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Aug 6 - 1960 | |
| 23c. NAME OF CEMETERY OR CREMATORY Greek Orthodox | | 23d. LOCATION (City, town or county) (State) Woodlawn, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE John G. Connelly | | 25a. REC'D BY REGISTRAR AUG 5 '60 | |
| ADDRESS 3500 Bank St., Balto., Md. | | 25b. REGISTRAR'S SIGNATURE Arthur L. K... | |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 7/55

8904

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08877

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville | | c. LENGTH OF STAY IN 1b Cockeysville | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6 1/2 Parks Avenue | | d. STREET ADDRESS 6 Parks Avenue | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First MAHLON Middle McKINLEY Last POE | | 4. DATE OF DEATH Month August Day 17 , Year 1960 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH February 2, 1904 |
| 9. AGE (In years last birthday) 51 1/2 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Quarryman- retired | | 10b. KIND OF BUSINESS OR INDUSTRY H.T. Campbell Co. | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME George Clarence Poe | | 14. MOTHER'S MAIDEN NAME Emma Jane Brown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 216-07-5616 | |
| 17. INFORMANT Mrs. Mahlon M. Poe, Cockeysville, Maryland | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary Occlusion 7-20-1 DUE TO Arteriosclerotic Cardio- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Renal Vascular Disease 10 yrs DUE TO (c) 10 yrs INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 yrs | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE Charles H. Russell M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Aug. 20, 1960 | |
| 22c. NAME OF CEMETERY OR CREMATORY May's Chapel Cemetery | | 22d. LOCATION (City, town, or county) (State) Timonium, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland | | 24a. REC'D BY REGISTRAR DATE AUG 24 60 | |
| | | 24b. REGISTRAR'S SIGNATURE John A. Burns | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9-59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

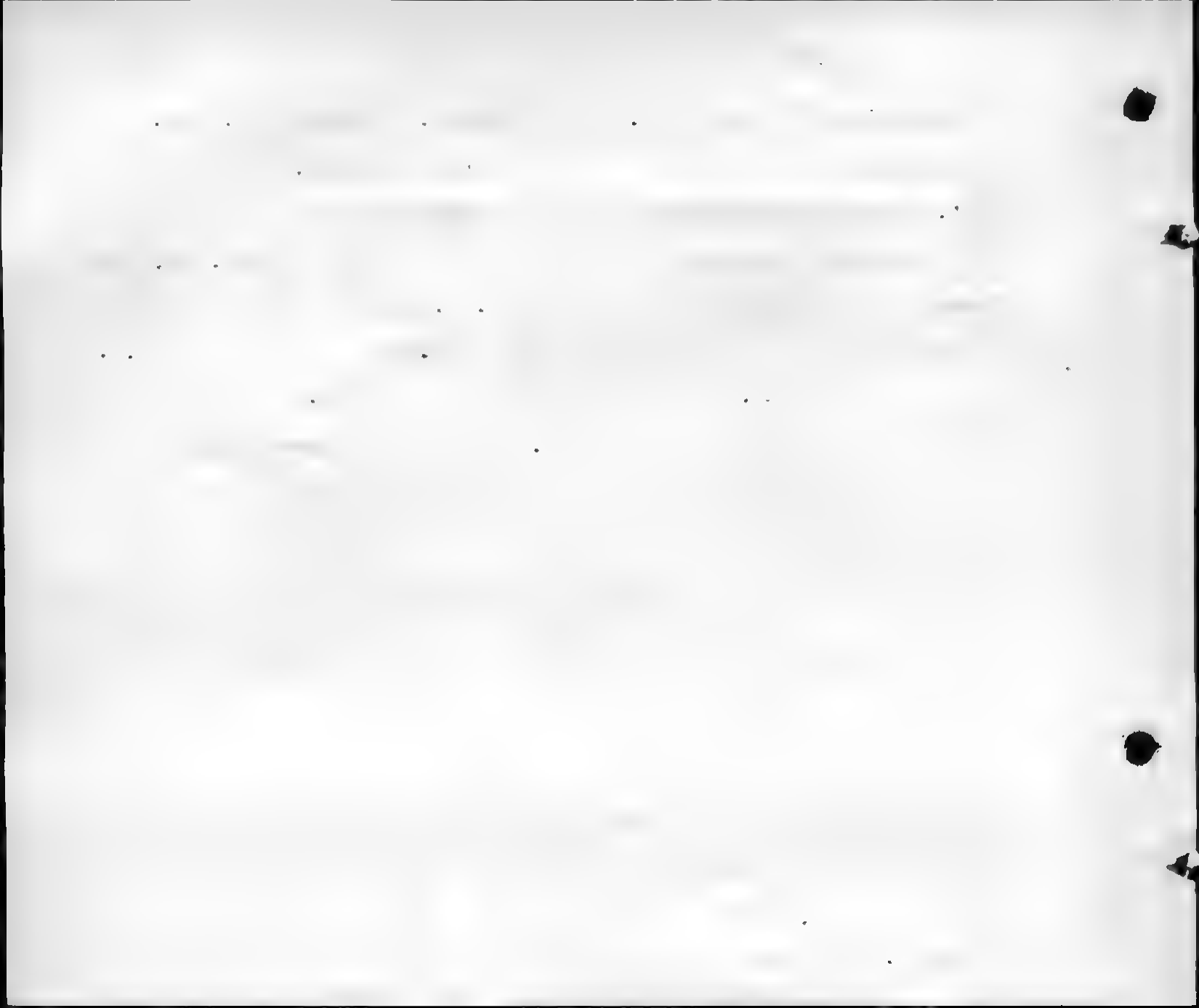
8905

CERTIFICATE OF DEATH

Item 2 Film 71-9-14-60 et

08878

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Catonsville Baltimore Co. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY 140 S. Patterson Pl. Ave. City c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Baltimore Md. 31 | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Joseph Nursing Home | | d. STREET ADDRESS 133 N. Collington Ave. Tugwell Drive | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Aniela Polkowski | | 4. DATE OF DEATH Month Day Year Aug. 24. 1960 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 1. 1882 |
| 9. AGE (In years lost birthday) 78 yrs | | 10. IF UNDER 1 YEAR F UNDER 24 HRS Months 23 Hours 28 Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife | | 10b. KIND OF BUSINESS OR INDUSTRY Poland | |
| 11. BIRTHPLACE (State or foreign country) Poland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 13. FATHER'S NAME Unk. | | 14. MOTHER'S MAIDEN NAME Unk. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. Sr. M. Laurentia Tugwell Drive | |
| 17. INFORMANT Sr. M. Laurentia Tugwell Drive | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Arteriosclerosis Conditions if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (b) Arteriosclerosis DUE TO (c) Arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH 15 min 7 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS A T.O.P.S.Y. PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from June 1960 to August 1960 that (I) (we) last saw the deceased alive on July 7 1960 , and that death occurred at 7 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Walter E. James | | 22b. DATE SIGNED 8/25/60 | |
| 22c. PHYSICIAN'S NAME (Type) Walter E. James, M.D. | | 22d. ADDRESS 5550 Baltimore National Pk., Balt 28, Md. | |
| 23a. BURIAL CREMATION REMOVAL (Specify) Burial | | 23b. DATE THEREOF Aug. 26/60 | |
| 23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Of Mary | | 23d. LOCATION (City, town, or county) (State) Baltimore | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Fred W. Ozazewski | | 25a. REC'D BY REGISTRAR AUG 26 1960 | |
| ADDRESS 1930 Eastern Ave | | 25b. REGISTRAR'S SIGNATURE Walter E. James | |



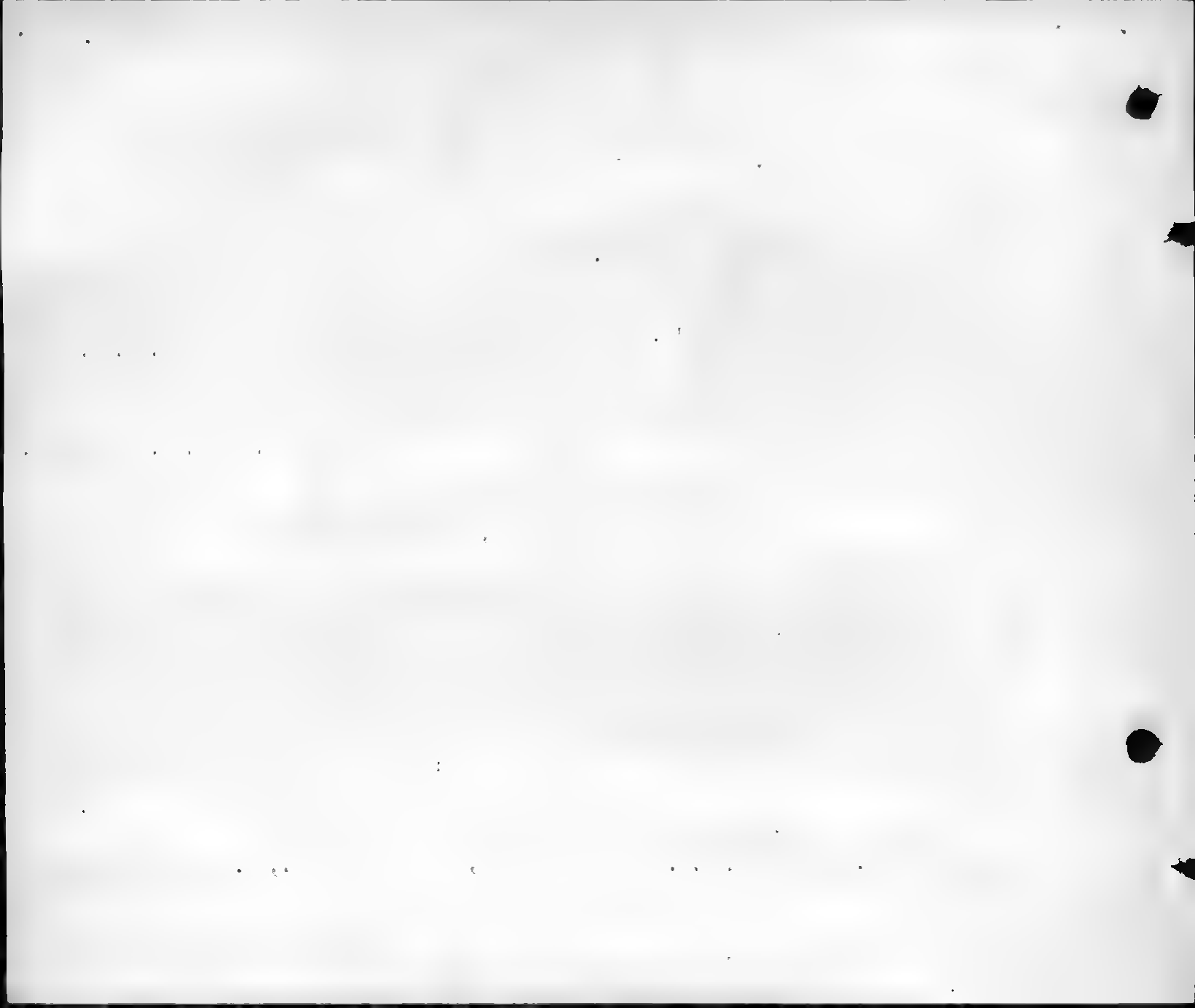
8906

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08879.

| | | | | | | | |
|---|----------------------------------|--|--|--|--|--|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md. | | | | c. LENGTH OF STAY IN 1b 61 Days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis | | | |
| f. STREET ADDRESS 101 Chesapeake Avenue | | | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3 NAME OF DECEASED (Type or print) First EUGENE Middle D. Last RECKNER | | | | 4 DATE OF DEATH Month August Day 8 Year 1960 | | | |
| 5 SEX Male | 6. COLOR OR RACE White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH May 14, 1899 | 9 AGE (In years last birthday) 61 yrs | 10 IF UNDER 1 YEAR Months 61 Days 0 Hours 0 Min 0 | 11 IF UNDER 24 HRS. Hours 0 Min 0 | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter-Retired | | 10b KIND OF BUSINESS OR INDUSTRY (Gov't Civil Service) Naval Academy, | | 11 BIRTHPLACE (State or foreign country) Meyersdale, Pennsylvania | | 12 C ITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Hezekiah Reckner | | | | 14 MOTHER'S MAIDEN NAME Lillian Mull | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16 SOCIAL SECURITY NO WW I | | 17 INFORMANT Clinical Records, VAH, Balto. 18, Md. Ft. Howard Div. | | | |
| 18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, BILATERAL DUE TO BRONCHOGENIC CARCINOMA, LEFT UPPER LOBE Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) UNKNOWN (c) UNKNOWN | | | | | | INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIOSCLEROSIS, MARKED, GENERALIZED -OLD | | | | | | 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c TIME OF INJURY Month, Day, Year Hour 0 a. m. 19 p. m. | | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f (City or town) (County) (State) | |
| 21 I certify that (a) (this hospital) attended the deceased from June 8, 1960 to August 8, 1960 . that (b) (we) last saw the deceased alive on August 8, 1960 , and that death occurred at 7:43 P M, from the causes and on the date stated above. | | | | | | | |
| 22a SIGNATURE FREDERICK S. DONALDSON, M.D. | | | | 22b DATE SIGNED 8/9/60 | | 22c PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D. | |
| 22d ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b DATE THEREOF 8-12-60 | | 23c NAME OF CEMETERY OR CREMATORY Hillcrest Memorial Cemetery Annapolis, Maryland | | 23d LOCATION (City, town or county) (State) | |
| 24 FUNERAL DIRECTOR'S SIGNATURE William Cook-Blight, Inc. | | | | 25a REC'D BY REGISTRAR AUG 12 '60 | | 25b REGISTRAR'S SIGNATURE Arthur L. Thomas | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The attending physician or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

VR AIS (4)
ISM 9/59

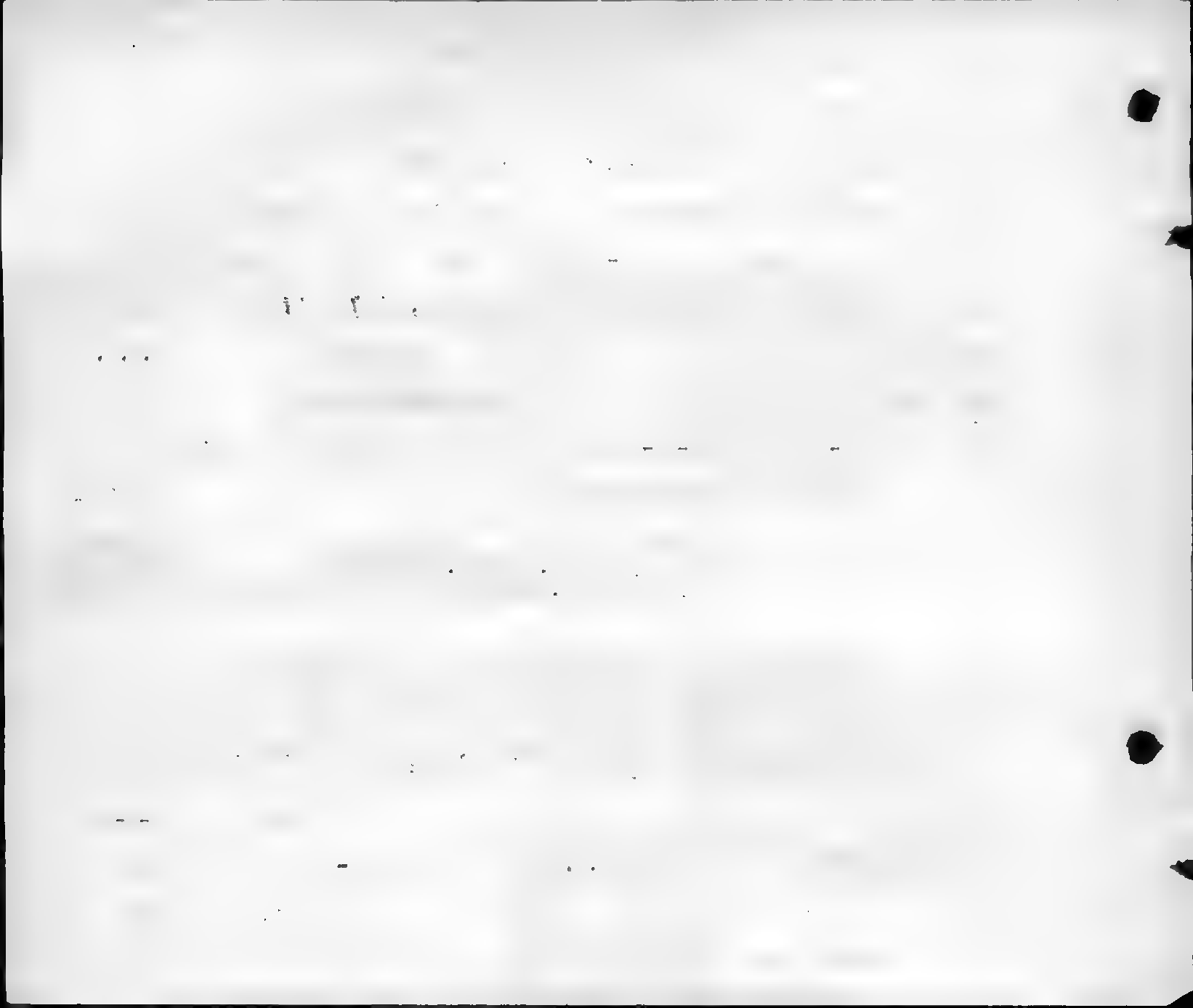
1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8907
CERTIFICATE OF DEATH

08880

| | | | |
|---|---------------------------------|--|--|
| 1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | c. LENGTH OF STAY IN 1b 16 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE | |
| | | d. STREET ADDRESS 1215 EAST CHASE STREET | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3 NAME OF DECEASED (Type or print) First ARTHUR Middle -- Last REDD | | 4. DATE OF DEATH Month AUGUST Day 4 Year 19 60 | |
| 5 SEX MALE | 6 COLOR OR RACE NEGRO | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH JANUARY 17, 1889 |
| 9 AGE (In years last birthday) 71 yrs | | 10 UNDER 1 YEAR: Months 7 Days 1 Hours 1 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11 BIRTHPLACE (State or foreign country) VIRGINIA | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JOHN REDD | | 14 MOTHER'S MAIDEN NAME MELINDA CHICKAWOOD | |
| 15 WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES WW-1 | | 16. SOCIAL SECURITY NO 220-09-0002 | |
| 17. INFORMANT CLIN REC VAH BALTO MD FT HOWARD DIV | | Address | |
| 18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA RECENT | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) EMPHYSEMA UNKNOWN | | | |
| (c) ARTERIOSCLEROSIS, MARKED, GENERALIZED UNKNOWN | | | |
| (c) AORTIC ANEURYSM, ABDOMINAL UNKNOWN | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day Year Hour a. m. 19 p. m. | | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f (City or town) (County) (State) | |
| 21 I certify that X (this hospital) attended the deceased from July 19, 1960 to August 4, 1960 , that X (we) last saw the deceased alive on August 4, 1960 , and that death occurred at 11:15 AM , from the causes and on the date stated above | | | |
| 22a. SIGNATURE HOWARD KRAMER | | 22b. DATE SIGNED 8-4-60 | |
| 22c. PHYSICIAN'S NAME (Type) HOWARD KRAMER | | 22d. ADDRESS VAH BALTO MD * FT HOWARD DIVISION | |
| 23a BURIAL CREMATION REMOVAL (Specify) BURIAL | | 23b DATE THEREOF 8-8-60 | |
| 23c NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL | | 23d LOCATION (City, town, or county) (State) BALTIMORE MARYLAND | |
| 24 FUNERAL DIRECTOR'S SIGNATURE Collick Funeral Home | | 25a REC'D BY REG STRAR 112 E Preston St Baltimore Maryland | |
| 25b REG STRAR'S SIGNATURE Arthur S. Kraus | | DATE AUG 9 '60 | |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, it should be executed the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8908

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08881

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 1 | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks Pt-19 | | c. LENGTH OF STAY IN 1b — | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Beau Creek | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk | |
| f. STREET ADDRESS 3007 Dunglow Road | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Willis Hauck Middle Reisinger Last Reisinger | | 4. DATE OF DEATH Aug 4/60 9 Month Day Year 19 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH November 29 1928 9. AGE (In years last birthday) 31 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) steam ship | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? Maryland | |
| 13. FATHER'S NAME Willis T Reisinger | | 14. MOTHER'S MAIDEN NAME Mildred N Hauck | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes 1948-1954 | | 16. SOCIAL SECURITY NO 217-24-2622 | |
| 17. INFORMANT Willis T Reisinger | | Address 3007 Dunglow Road | |
| 18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 850X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH — | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Upsawing life from Boat into Beau Creek | |
| 20c. TIME OF INJURY Month, Day, Year 7 Hour 8-3 19 60 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/> Beau Creek | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Beau Creek | | 20f. CITY or town Sp. Pt-19 (County) Baltimore (State) MD | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE M.B. Davis M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) M.B. Davis, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, or other disposal (Specify) Burial | | 22b. DATE THEREOF Aug 6/60 | |
| 22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | | 22d. LOCATION (City, town, or county) (State) Baltimore | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave | | 24a. REC'D BY REGISTRAR DATE AUG 9 '60 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur S. Hume | |

DATE SIGNED
8/5/60.



1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

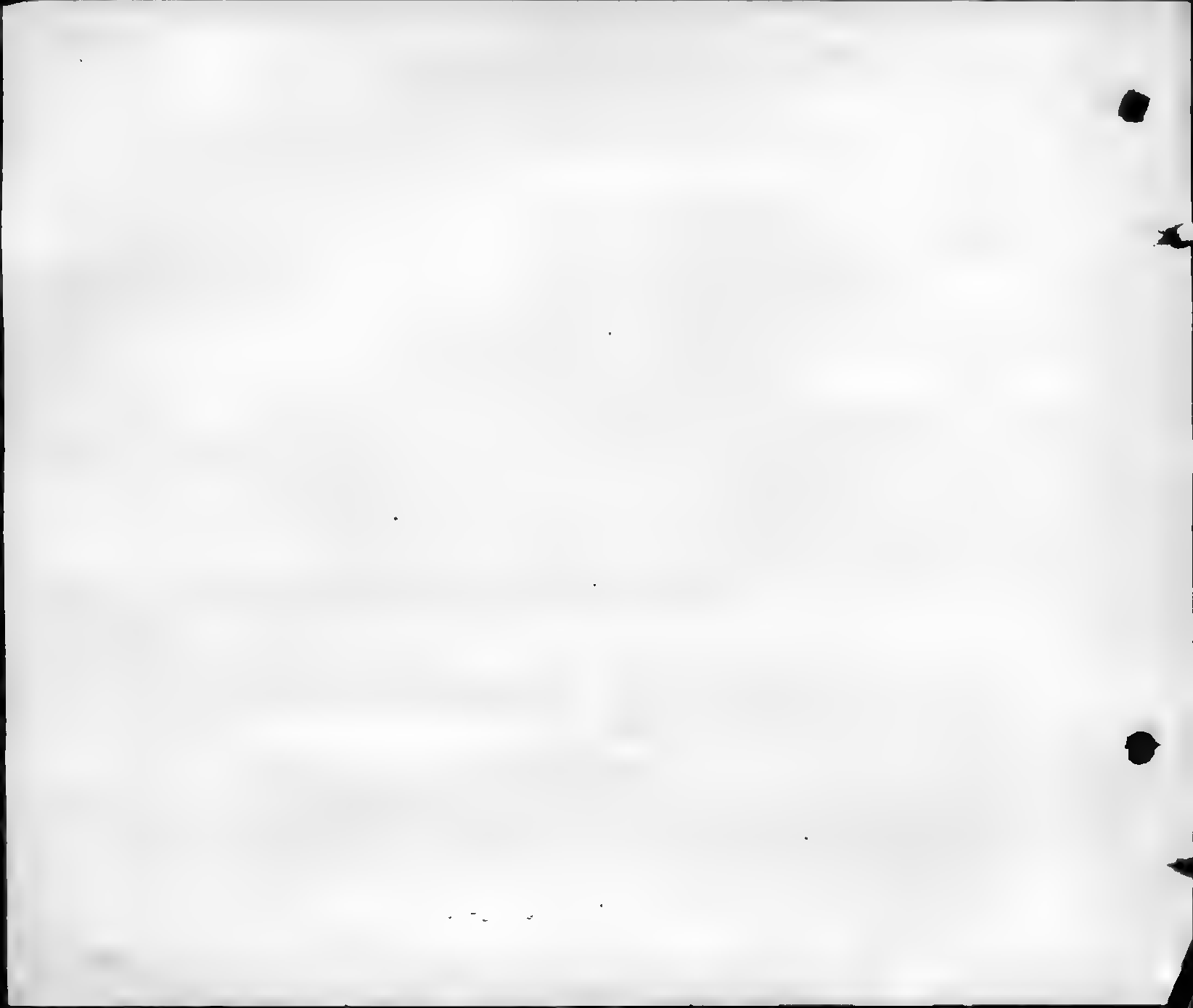
89001

CERTIFICATE OF DEATH

10025

Item 11 Filed 10-14-60 et

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u> | | d. STREET ADDRESS <u>1523 Eutaw Place</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>Jane</u> Last <u>Reno</u> | | 4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>1960</u> | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2 1895</u> |
| 9. AGE (In years last birthday) <u>64</u> yrs | | 10. UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> | |
| 10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u> </u> | |
| 11. BIRTHPLACE (State or foreign country) <u>West Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Andy Sheets</u> | | 14. MOTHER'S MAIDEN NAME <u>Pauline Gady</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u> | | 16. SOCIAL SECURITY NO <u> </u> | |
| 17. INFORMANT <u>Records: Spring Grove State Hospital - Catonsville - Md.</u> | | Address <u> </u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>450.0</u> DUE TO <u>15 hrs</u> Status Epilepticus & Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last DUE TO (b) <u>Chronic Brain Syndrome - Senile Brain Disease - Convulsive Disorder</u> (c) <u> </u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | |
| 20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u>a. m.</u> p. m. <u> </u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u> |
| 21. I certify that (I) (this hospital) attended the deceased from <u>August 21, 1960</u> , to <u>August 21, 1960</u> , that (I) (we) last saw the deceased alive on <u>August 21, 1960</u> , and that death occurred at <u>9:25 M.</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Gert R. Fleischman</u> M.D. | | 22b. DATE <u>Aug 21 1960</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>GERT RUDOLF FLEISCHMAN</u> | | 22d. ADDRESS <u>42 Maple Drive, Cat.</u> | |
| 23a. BURIAL - CREMATION REMOVAL (Specify) <u> </u> | 23b. DATE THEREOF <u>9.30.60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Worshipful Mch. School</u> | 23d. LOCATION (City, town or county) <u>Baltimore, Md.</u> (State) <u> </u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u> </u> ADDRESS <u> </u> | | 25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u> </u> | |
| DATE <u>OCT 3 '60</u> | | <u> </u> | |



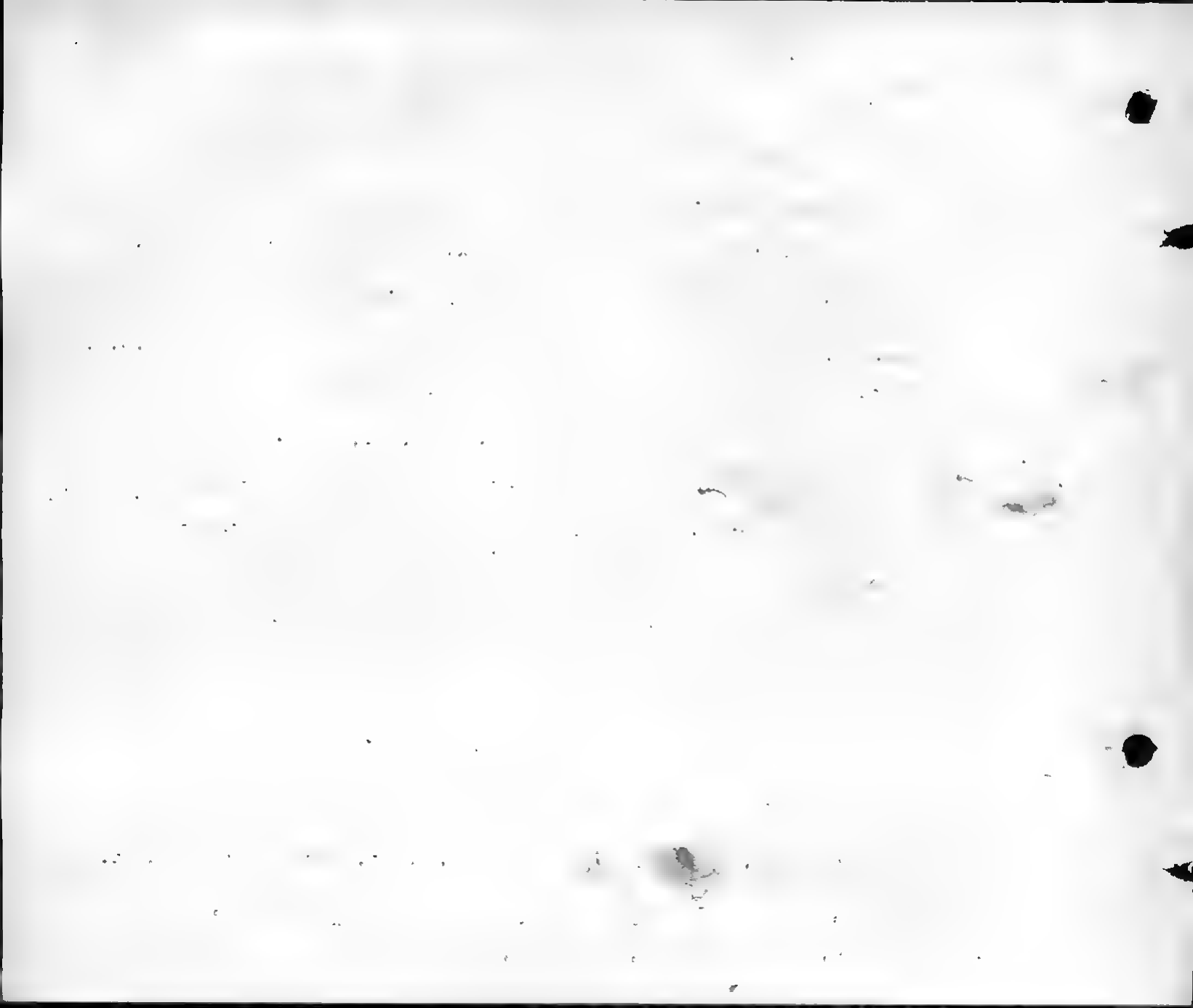
89111

CERTIFICATE OF DEATH

Reg. Dist. No.

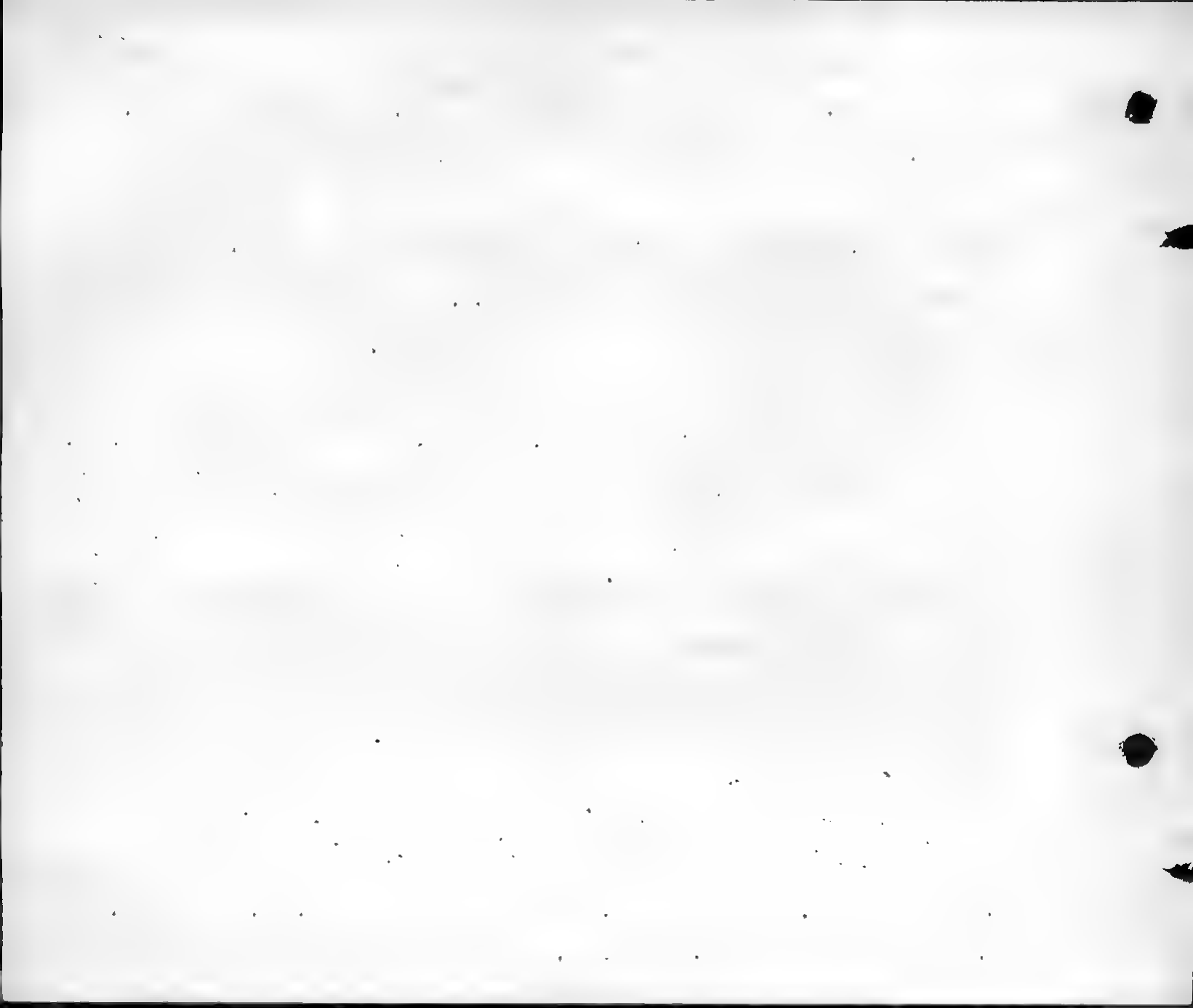
| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5 Burke Avenue | | d. STREET ADDRESS 5 Burke Avenue | |
| 3. NAME OF DECEASED (Type or print) First Suzanne Middle Reus Last Reus | | 4. DATE OF DEATH Month August Day 8 Year 1960 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 22, 1888 |
| 9. AGE (In years, last birthday) 72 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Baltimore | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Thomas Vaughan | | 14. MOTHER'S MAIDEN NAME Alice Pulliam | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 1 | | 16. SOCIAL SECURITY NO (If yes, give war or dates of service) John F. Reus, Jr., 5 Burke Avenue, Towson 4 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHO PNEUMONIA BILATERAL 422.1 DUE TO ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE WITH CONGESTIVE FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE WITH CONGESTIVE FAILURE (c) HEPATIC CIRRHOSIS WITH ASCITES & DEPENDENT EDEMA PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HEPATIC CIRRHOSIS WITH ASCITES & DEPENDENT EDEMA | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 4/29, 1960 to 8/8, 1960 , that I last saw the deceased alive on 8/7, 1960 , and that death occurred at 12:35 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) 206 W. Penna. Avenue, Towson 4, Md. DATE SIGNED 8/8/60 | | | |
| ACTUAL SIGNATURE T. C. Siwinski | | M.D. 8/8/60 | |
| PHYSICIAN'S NAME (Type) Thaddeus C. Siwinski | | 206 W. Penna. Avenue, Towson 4, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 8-10-60 | 22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery | 22d. LOCATION (City, town, or county) (State) Pikesville 8, Md |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, 1850 York Road, Towson 4, Md | | 24. REGISTRY BY REGISTRY AUG 10 1960 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Hume | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and any event within 72 hours after death.



CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Balto. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Glen Falls Road | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown | |
| f. STREET ADDRESS Glen Falls Road | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Gerdetta Middle Effie Last Rimbey | | 4. DATE OF DEATH Month Aug. Day 1, Year 1960 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 3, 1879 |
| 9. AGE (In years last birthday) 80 yrs | 10. UNDER 1 YEAR Months 80 Days 0 Hours 0 Min 0 | 11. UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0 | 12. CITIZEN OF WHAT COUNTRY? USA |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Penna. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William Smith | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO None | |
| 17. INFORMANT Mr. George C. Rimbey | | Address Reisterstown, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443 X DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour 0 m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1960 to 1960 , that I last saw the deceased alive on Aug. 3, 1960 and that death occurred at Md. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE J. F. Eline & Sons M.D. | | | |
| PHYSICIAN'S NAME (Type) Reisterstown, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Aug. 3, 1960 | 22c. NAME OF CEMETERY OR CREMATORY Mt. Gilead | 22d. LOCATION (City, town, or county) (State) Balto. Co. Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons | | ADDRESS Reisterstown, Md. | |
| 24a. REC'D BY REGISTRAR DATE AUG 4 '60 | | 24b. REGISTRAR'S SIGNATURE Charles S. Kraus | |



8799

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08884

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 202 Hillendale Road | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Barbara Middle D. Last Robinson | | | | 4. DATE OF DEATH Month August Day 1 Year 1960 | | | |
| 5. SEX female | | 6. COLOR OR RACE white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH June 28, 1895 | |
| 9. AGE (In years last birthday) 65 yrs. | | 10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 | | 11. IF UNDER 24 HRS Hours 0 Min. 0 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | | | | |
| 13. FATHER'S NAME John Walz | | | | 14. MOTHER'S MAIDEN NAME Barbara ? | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Walter W. Robinson 202 Hillendale Rd. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Arteriosclerotic CVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ? (c) yp. INTERVAL BETWEEN ONSET AND DEATH Sudden | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Diabetes mellitus 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from June 1952 to August 1, 1960 , that (I) (we) last saw the deceased alive on 7/28 1960 , and that death occurred at 8 A.M. from the causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE Herbert J. Levickas M.D. | | | | 22b. DATE 8/2/60 | | 22c. ADDRESS 5305 East Drive or 2436 Wash. Blvd. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE THEREOF 8/4/60 | | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery | |
| 23d. LOCATION (City, town, or county) (State) Elkridge, Maryland | | | | 24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard 4107 Wilkens Avenue | | 25a. REC'D BY REGISTRAR DATE AUG 4 '60 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Kline | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8911

10031

| | | | | | | | |
|---|----------------------------------|---|---|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md. | | | | c. LENGTH OF STAY IN TB 2 Days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie | | | |
| | | | | d. STREET ADDRESS 305 Raleigh Road | | | |
| 3. NAME OF DECEASED (Type or print) First HAROLD Middle M. Last ROBINSON | | | | 4. DATE OF DEATH Month August Day 30 Year 1960 | | | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH September 14, 1909 | | 9. AGE (In years last birthday) 50 yrs | IF UNDER 1 YEAR Months Days Hours Min | IF UNDER 24 HRS Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Fitter | | | 10b. KIND OF BUSINESS OR INDUSTRY Chemical Company Virginia | | | 11. BIRTHPLACE (State or foreign country) U. S. A. | |
| 13. FATHER'S NAME George Thomas Robinson | | | | 14. MOTHER'S MAIDEN NAME Queen Matthews | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 217-14-1576 | | 17. INFORMANT Clinical Records, VAH, Balto. 18, Md. FT. HOWARD DIV. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, RIGHT LUNG 1991X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE XXXX (c) ACUTE GASTRITIS | | | | | | | INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN RECENT |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ACUTE TOXIC HEPATITIS, RECENT | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (X) (this hospital) attended the deceased from August 28, 1960 , to August 30, 1960 , that (if we) last saw the deceased alive on August 30, 1960 , and that death occurred at 11:05 A. M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <i>Frederick S. Donaldson</i> | | | | M. D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 8/30/60 | |
| 22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D. | | | | 22d. ADDRESS VAH, BALTO. 18 MD, FORT HOWARD DIVISION | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8-4-60 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem. | | 23d. LOCATION (City, town, or county) (State) Baltimore Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Elroy Wilson, 1000 Brantley Ave., Balto. Md. | | | | 25a. REC'D BY REGISTRAR DATE SEP 13 '60 | | 25b. REGISTRAR'S SIGNATURE <i>William S. Thomas</i> | |

the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

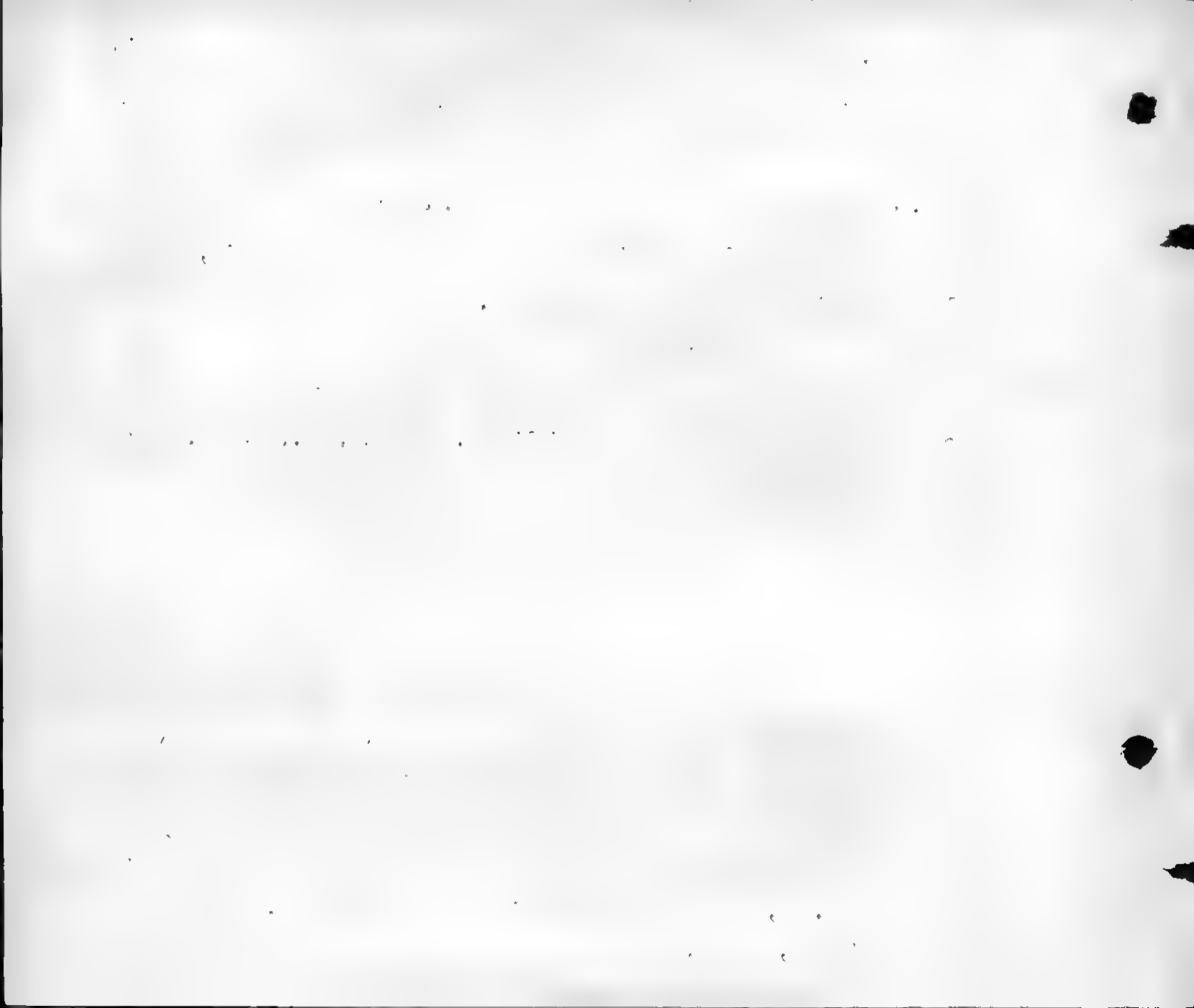
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

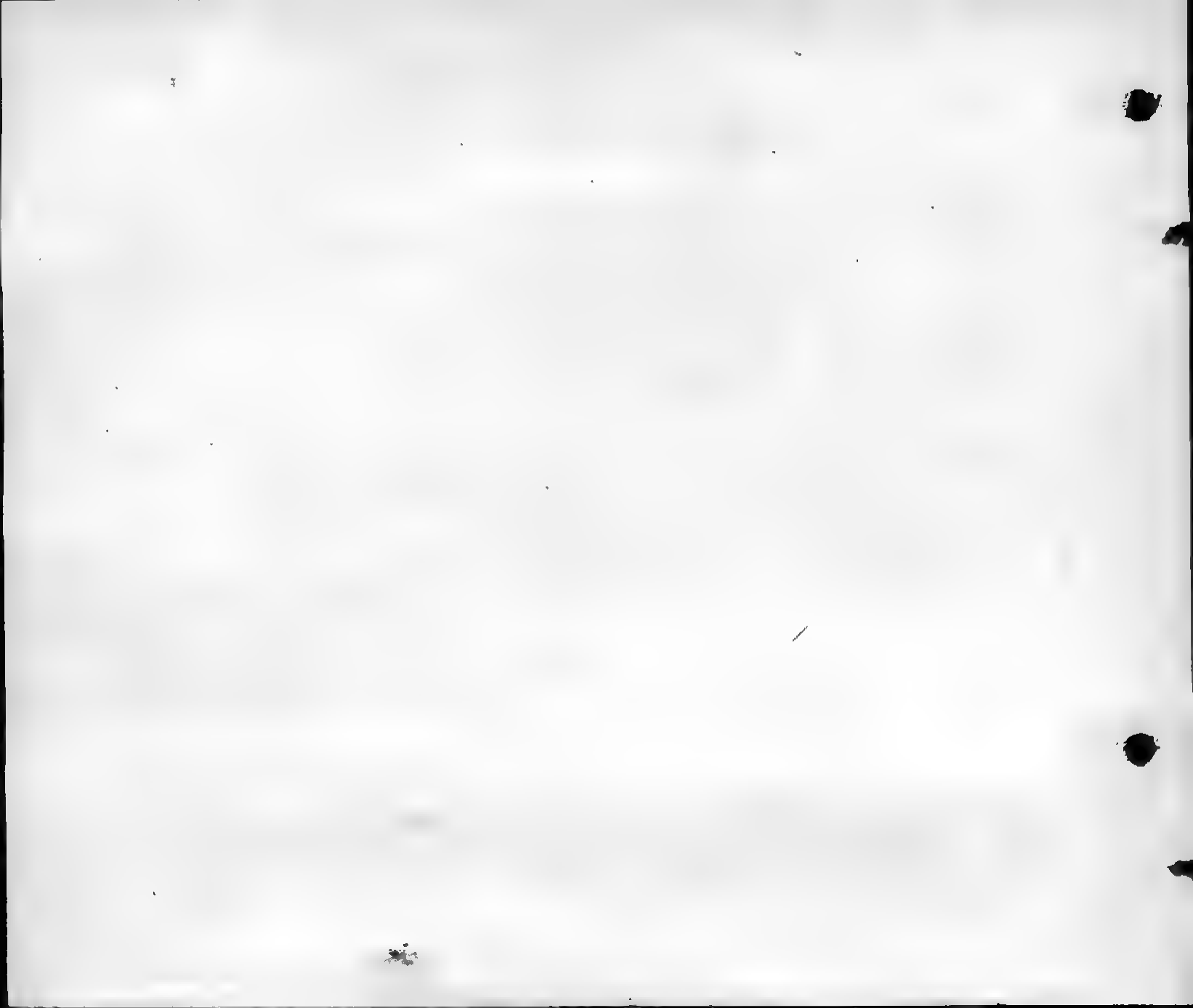
CERTIFICATE OF DEATH

8912

08885

| | | | |
|--|---------------------------------|--|---|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | c. LENGTH OF STAY IN 1b 55 | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 613 E. Joppa Road | | d. STREET ADDRESS 613 E. Joppa Road | |
| e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Muriel Alice Robinson | | 4. DATE OF DEATH Month Day Year August 14, 1960 | |
| 5 SEX Female | 6 COLOR OR RACE White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 12, 1914 |
| 9. AGE (In years last birthday) 45 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11 BIRTHPLACE (State or foreign country) New York | | 12 CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Peter Caddell | | 14. MOTHER'S MAIDEN NAME Harriett Burns | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None | | 16. SOCIAL SECURITY NO. William S. Robinson, Sr., Towson, Maryland | |
| 17. INFORMANT William S. Robinson, Sr., Towson, Maryland | | Address | |
| 18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Liver 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) Carcinoma Rt. Breast DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day Year Hour a m p m 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21 I certify that (I) (this hospital) attended the deceased from May 10, 1960 to Aug 14, 1960 , that (I) (was) last saw the deceased alive on Aug 14 19 60 , and that death occurred at 9:20 P. from the causes and on the date stated above. | | | |
| 21a. SIGNATURE Laurence C. Post | | 21b. DATE SIGNED 8/16/60 | |
| 22c. PHYSICIAN'S NAME (Type) LAURENCE C. POST | | 22d. ADDRESS 6805 York Rd. Baltimore 12 Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Aug. 17, 1960 | |
| 23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park | | 23d. LOCATION (City, town, or county) (State) Parkville, Maryland | |
| 24 FUNERAL DIRECTOR'S SIGNATURE John Burns Sons, Towson, Maryland | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |
| 25a. REC'D BY REGISTRAR AUG 19 '60 | | 25b. REGISTRAR'S SIGNATURE | |





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

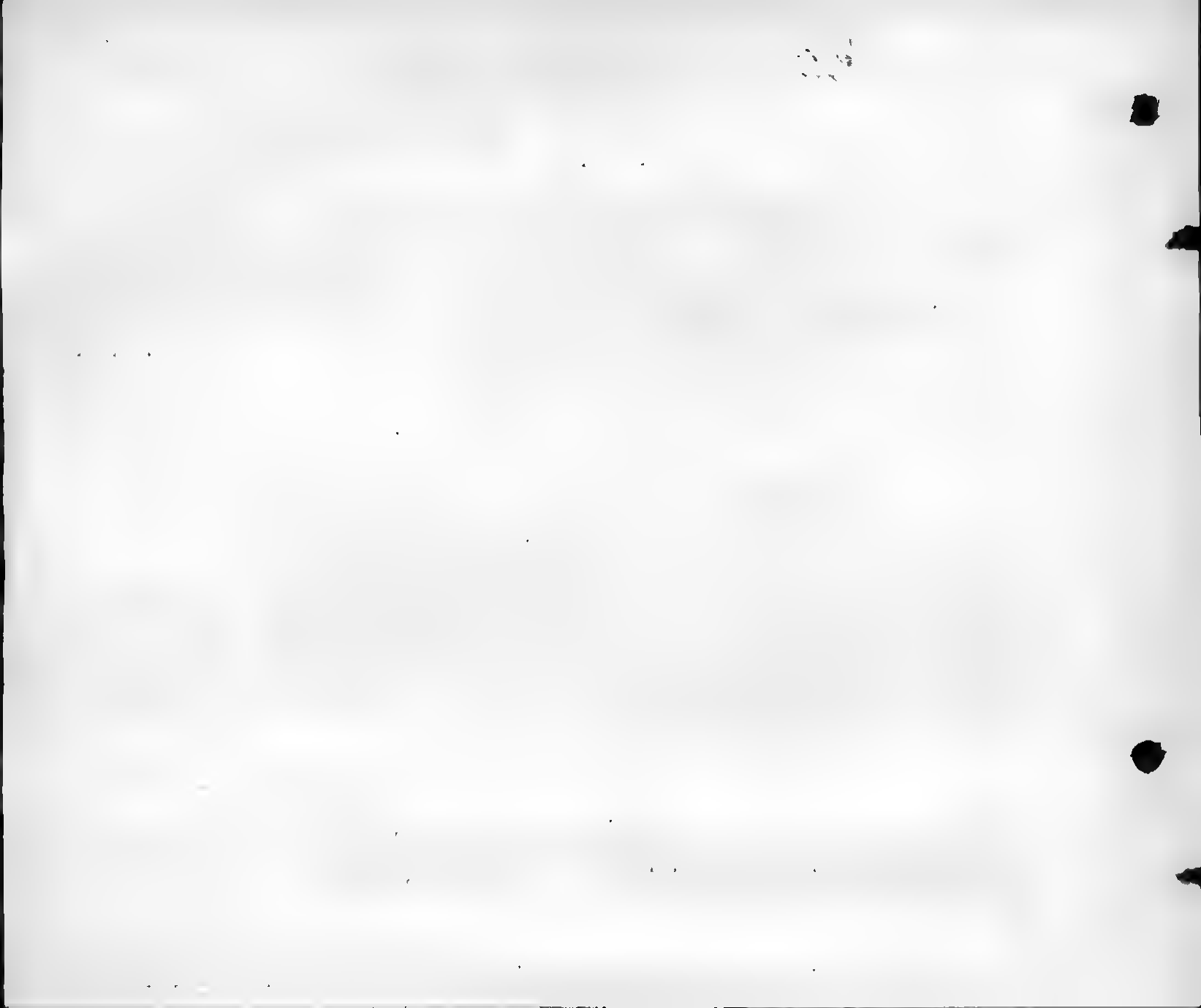
8914

CERTIFICATE OF DEATH

08887
Reg. Dist. No

| | | | |
|--|----------------------------------|---|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 31 Yrs. 2 Mos. 2 Ds. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sheppard and Enoch Pratt Hospital | | 2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Ohio b. COUNTY Dover c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dover d. STREET ADDRESS Cumberland Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First Louise Middle Martha Last Scheffer | | 4. DATE OF DEATH Month August Day 23 Year 1960 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 8, 1875 |
| 9. AGE (In years last birthday) 85 yrs. | | IF UNDER 1 YEAR Months 23 Days 19 Hours 60 | IF UNDER 24 HRS Months 23 Days 19 Hours 60 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME | |
| 11. BIRTHPLACE (State or foreign country) Ohio | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Jeremiah Reeves | | 14. MOTHER'S MAIDEN NAME Jane Rees | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give year or dates of service) No | | 16. SOCIAL SECURITY NO NONE | |
| 17. INFORMANT HOSPITAL RECORDS | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 432-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial fibrosis DUE TO (c) Generalized Atherosclerosis | | | |
| INTERVAL BETWEEN ONSET AND DEATH 2 weeks 5 Years 15 Years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cold abscess, old, of the spine, resulting from lesion of coccyx. | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 21, 1929 , to Aug 23, 1960 , that I last saw the deceased alive on Aug 22, 1960 , and that death occurred at 6:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Dover, Ohio DATE SIGNED August 23, 1960 | | | |
| ACTUAL SIGNATURE Harry M. Murdock M.D. | | The Sheppard and Enoch Pratt Hospital Towson 4, Maryland | |
| PHYSICIAN'S NAME (Type) Harry M. Murdock, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | |
| REMOVAL/BURIAL AUG. 26, 1960 | | MAPLE GROVE CEM. | |
| 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| DOVER, OHIO | | DOVER, OHIO | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland | | ADDRESS | |
| 24a. REC'D BY REGISTRAR AUG 26 '60 | | 24b. REGISTRAR'S SIGNATURE William S. Frank | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1.

8915

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10039

| | | | |
|---|-------------------------------|--|---------------------------------------|
| 1 PLACE OF DEATH a COUNTY Baltimore b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | 2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY | |
| c. LENGTH OF STAY IN 76 6 Hours | | c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Baltimore, 30 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | d. STREET ADDRESS 2620 Kent Street | |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle C. Last SCHULTZ | | 4. DATE OF DEATH Month August Day 31 Year 19 60 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 8, 1907 |
| 9. AGE (In years last birthday) 53 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook | | 10b. KIND OF BUSINESS OR INDUSTRY Seton Institute | |
| 11. BIRTHPLACE (State or foreign country) Lovejoy, Illinois | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Don Schultz | | 14. MOTHER'S MAIDEN NAME Ella Randolph | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Clin. Rec. VAH, Baltimore 18, Md. FT. HOWARD DIVISION | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 434.4 IMMEDIATE CAUSE (a) COR PULMONALE Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) DUE TO (c) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH UNKNOWN | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (a) (This hospital) attended the deceased from 8/31/60 1:00 PM to 8/31/60 7:00 PM , that (b) (we) last saw the deceased alive on 8/31/60 19 60 , and that death occurred at 7 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Frederick S. Donaldson M.D. | | 22b. DATE SIGNED 8 9/1/60 | |
| 22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D. | | 22d. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) Burial | | 23b. DATE THEREOF 9/6/1960 | |
| 23c. NAME OF CEMETERY OR CREMATORY Baltimore National | | 23d. LOCATION (City, town, or county) (State) Baltimore Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Isaiah Brown & Son, 108 W. Montgomery St. Balto. Md. | | 25a. REC'D BY REG STRAR SEP 8 1960 | |
| ADDRESS | | 25b. REG STRAR'S SIGNATURE | |

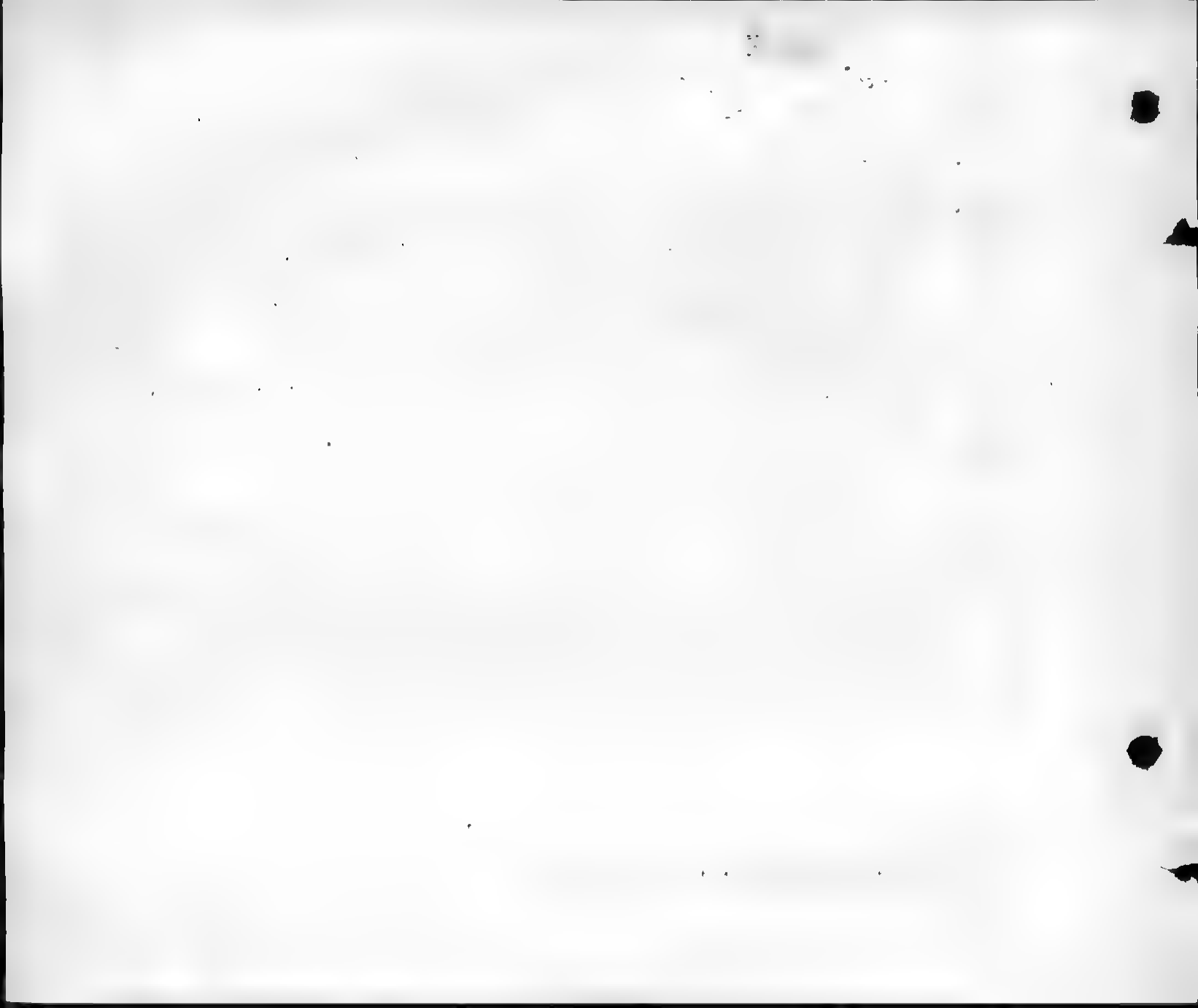


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8916
CERTIFICATE OF DEATH

08888
 Reg. Dist. No. 32

| | | | | | | | |
|---|--|--|--|--|--|--|---|
| 1 PLACE OF DEATH a COUNTY Baltimore County MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a STATE Maryland b COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland | | | | c. LENGTH OF STAY IN 1b 9 MOS. | | | |
| d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital | | | | d STREET ADDRESS Rt. I - 326 | | e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) BEULAH GENEVIEVE SCHULZE First Middle Last | | | | 4. DATE OF DEATH Month August Day 19 Year 1960 | | | |
| 5 SEX F | | 6. COLOR OR RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8 DATE OF BIRTH 7.5.1896. | |
| 9. AGE (in years last birthday) 64 yrs | | IF UNDER 1 YEAR Months Days Hours Min | | IF UNDER 24 HRS Months Days Hours Min | | | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cafeteria worker | | | | 10b KIND OF BUSINESS OR INDUSTRY | | 11 BIRTHPLACE (State or foreign country) Baltimore, Md. | |
| 12 CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13 FATHER'S NAME FRED COMLEY | | | | 14 MOTHER'S MAIDEN NAME SARAH E. PORTER | | | |
| 15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | | | 16 SOCIAL SECURITY NO 220-12-9762 | | INFORMANT Address Hospital Records, Mt. Wilson State Hospital | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 15 min |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO | | | | | | | |
| (c) DUE TO | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Toxic Goiter. 2. Minimal Pulmonary Tuberculosis | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) --- | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 11.30. , 19 57 to 8.19 , 19 60 , that I last saw the deceased alive on 8.19 , 19 60 , and that death occurred at 8 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE William Newcomer | | | | M.D. Mt. Wilson, Maryland | | | |
| PHYSICIAN'S NAME (Type) Wt. Newcomer, M.D. Superintendent | | | | | | | |
| 22a BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF Aug. 23 1960 | | 22c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. | | 22d. LOCATION (City, town, or county) (State) Glen Burnie Md. | |
| 23 FUNERAL DIRECTOR'S SIGNATURE Hopping & Kitchley | | | | 24a. REC'D BY REGISTRAR DATE AUG 23 '60 | | 24b. REGISTRAR'S SIGNATURE Charles S. Frank | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.



8917

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|---------------------------------|--|-------------------------------------|--|------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>1</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | c. LENGTH OF STAY IN 1b <u>83</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Baltimore</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>6234 Falls Road</u> | | | | d. STREET ADDRESS <u>16234 Falls Road</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>HENRIETTA A. SCOTT</u> | | | | 4. DATE OF DEATH <u>Aug 3 1960</u> | | | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>COLORED</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug 16 1876</u> | 9. AGE (In years last birthday) <u>83</u> yrs | 10. UNDER 1 YEAR | 11. UNDER 24 HRS | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u> | | 11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD.</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>JOHN T. GREEN</u> | | | | 14. MOTHER'S MAIDEN NAME <u>SARAH DIXON</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO | | 17. INFORMANT <u>ESTER SCOTT-FALLS ROAD</u> Address <u>6234</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic valvular disease of heart</u> <u>421.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>athero-sclerosis</u> DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>24 years</u> <u>34 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>June 10</u> , 19 <u>60</u> , to <u>8-3</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>8-2</u> , 19 <u>60</u> , and that death occurred at <u>9 P.</u> M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>John E. S. Camper</u> | | DATE SIGNED <u>8-5-60</u> | | ADDRESS (Street, city or town, state) <u>639b Carey St. Baltimore, Md.</u> | | DATE SIGNED | |
| PHYSICIAN'S NAME (Type) <u>JOHN E. T. CAMPER</u> | | ADDRESS <u>639b Carey St. Balto. Md.</u> | | DATE SIGNED | | DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>8/6/60</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>PUNXTON CEM.</u> | | 22d. LOCATION (City, town, or county) (State) <u>BALTO. CO MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Sutter</u> | | ADDRESS <u>3035 W. North Ave.</u> | | 24a. REGISTERED <input checked="" type="checkbox"/> DATE | | 24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hines</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



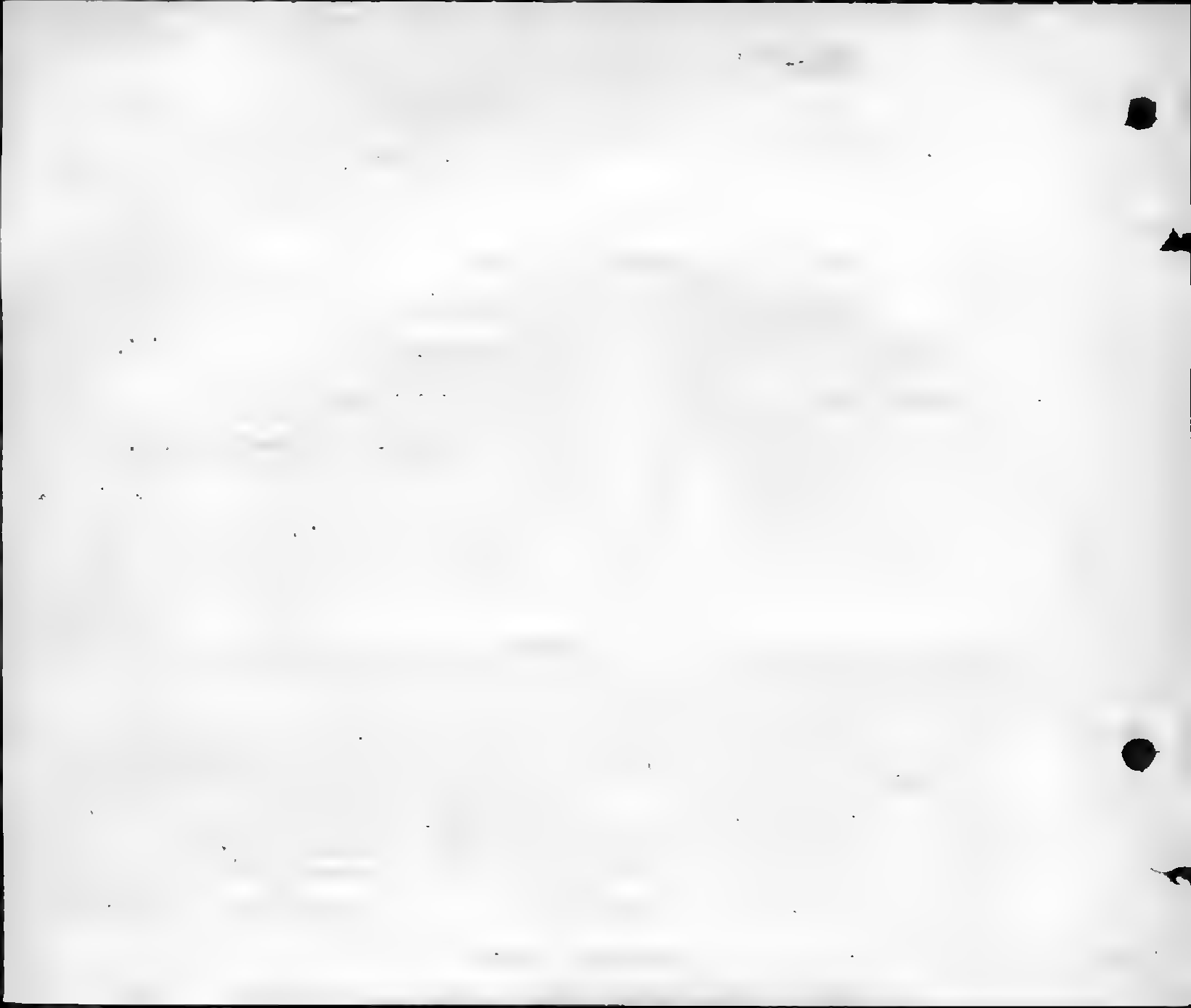
8918

CERTIFICATE OF DEATH

Item 1 ~~1318609-11-01~~

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the _____ or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



8803

CERTIFICATE OF DEATH

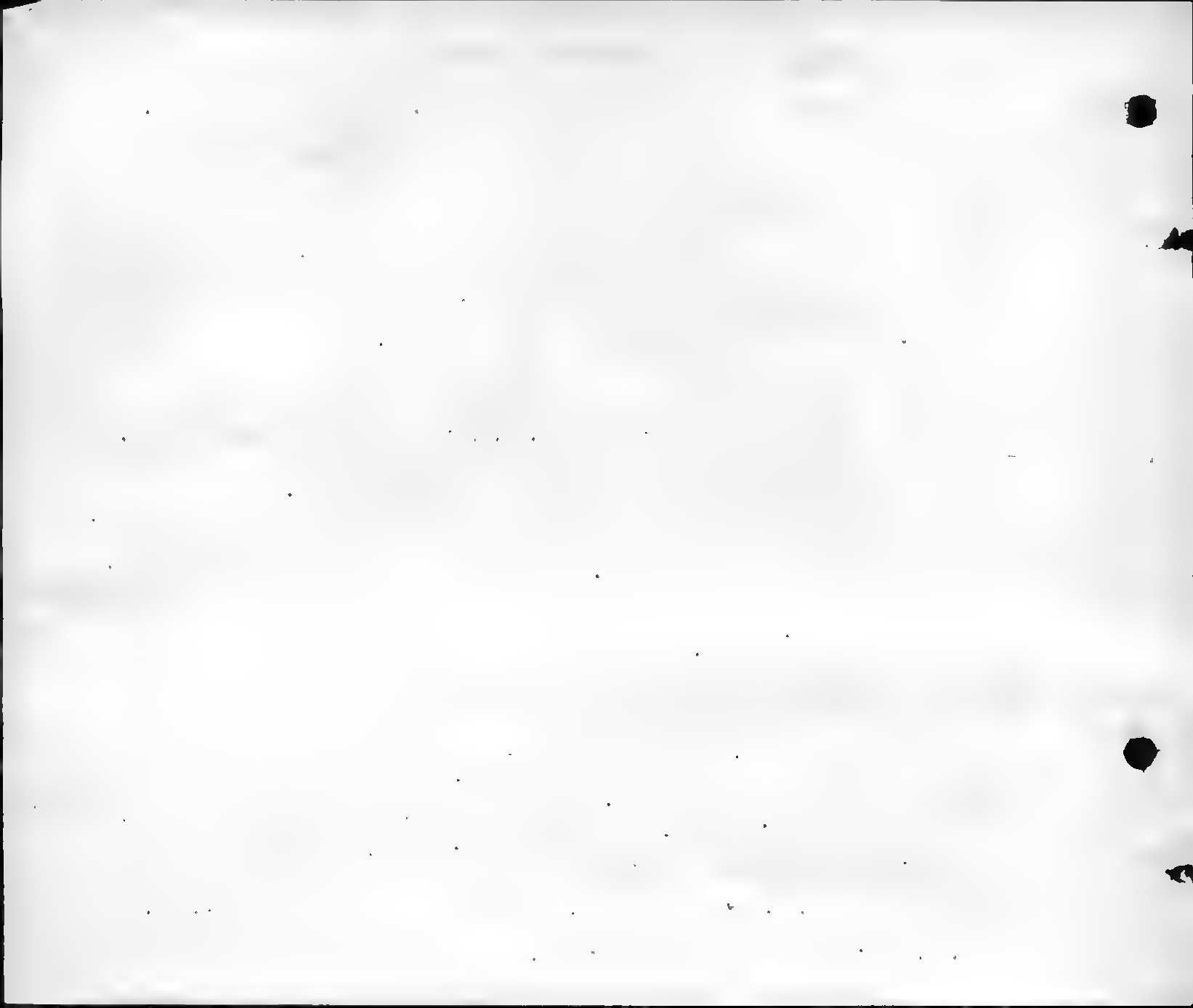
08891

Reg. Dist. No.

| | | | |
|--|--|---|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 112 Butler Road | | 2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown d. STREET ADDRESS 112 Butler Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Shaeffer | | 4. DATE OF DEATH Month August Day 17 Year 1960 | |
| 5 SEX Female | 6 COLOR OR RACE White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH May 20, 1879 |
| 9 AGE (In years last birthday) 81 yrs | | 10 IF UNDER 1 YEAR Months 1 Days 17 Hours 19 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11 BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Paterick McCartin | | 14. MOTHER'S MAIDEN NAME Mary Spencer | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) NO (If yes, give year or dates of service) NO | | 16 SOCIAL SECURITY NO None | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443 X DUE TO Ischemic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction DUE TO Coronary Atherosclerosis (c) Arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH 1 day | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 2 p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | | 20f. (City or town) (County) (State) | |
| 21 I certify that I attended the deceased from 10-17-60 to 10-19-60 , that I last saw the deceased alive on 10-19-60 , and that death occurred at 11 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Reisterstown, Md. DATE SIGNED 11-18-60 | | | |
| ACTUAL SIGNATURE J. F. Eline | | M.D. Arthur S. Kraus | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Aug. 20, 1960 | 22c. NAME OF CEMETERY OR CREMATORY All Saints Cemetery | 22d. LOCATION (City, town, or county) (State) Reisterstown, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons ADDRESS Reisterstown, Md. | | 24a. REC'D BY REGISTRAR DATE AUG 22 '60 | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8919

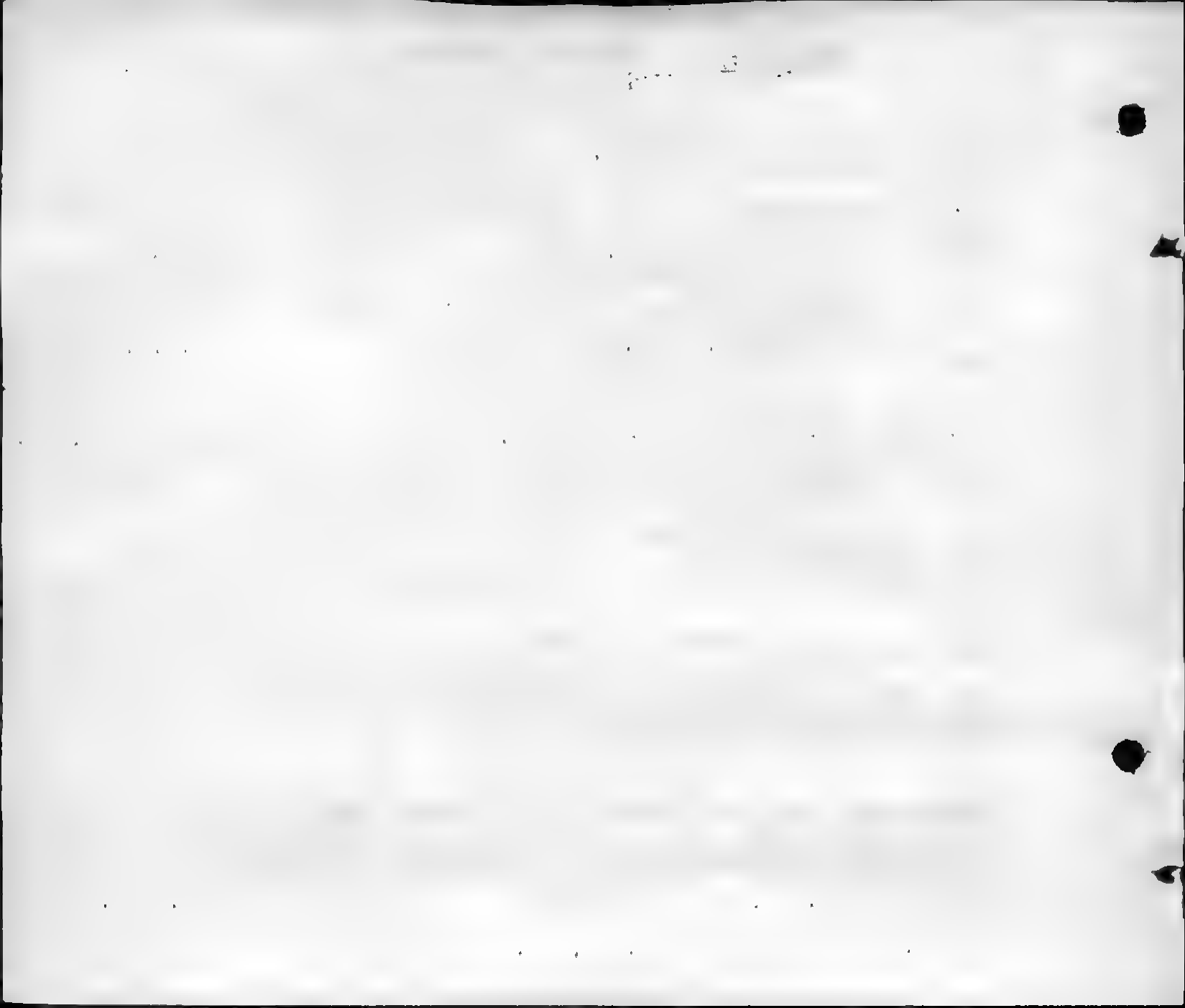
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | | |
| c. LENGTH OF STAY IN 1b 23 Yrs. | | | | d. STREET ADDRESS 15 Todd Avenue | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Res., 5 Todd Avenue | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Claude First L. Middle Sherow Last | | | | 4. DATE OF DEATH Month August Day 15 Year 1960 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH May 27, 1901 | |
| 9. AGE (In years last birthday) 59 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Potentialometer Oper. Beth. Steel | | | | 10b. KIND OF BUSINESS OR INDUSTRY New York | | 11. BIRTHPLACE (State or foreign country) U.S.A. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Jesse Sherow | | | | 14. MOTHER'S MAIDEN NAME Sarah Moore | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes-Army 1920-35 (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO 213-07-3628 | | 17. INFORMANT Mrs. Lucille Sherow Address 5 Todd Ave. 19, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis DUE TO 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adenocarcinoma Stomach DUE TO (c) | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 6 mos. 3 yrs. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) 19 | | | | 20g. (County) 19 | | 20h. (State) 19 | |
| 21. I certify that I attended the deceased from June , 19 58 , to Aug 15 , 19 60 , that I last saw the deceased alive on Aug 15 , 19 60 , and that death occurred at 12:30 P.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE James T. Means | | | | ADDRESS (Street, city or town, state) 5200 55th. Balto., 19 Md | | | |
| DATE SIGNED 8-17-60 | | | | | | | |
| PHYSICIAN'S NAME (Type) James T. Means | | | | M.D. MD | | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Aug. 18, 60 | | 22c. NAME OF CEMETERY OR CREMATORY Meadowridge | | 22d. LOCATION (C'ty, town, or county) (State) Washington Plvd. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA | | | | ADDRESS 7922 Wise Ave. 22, Md. | | 24a. REC'D BY REGISTRAR AUG 18 '60 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur J. K... | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8920 CERTIFICATE OF DEATH

08893

| | | | | | | | |
|---|---------------------------------|--|---|---|---|--|---|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY | | | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | c. LENGTH OF STAY IN 1b 9yr2mth2dys | | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | |
| d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | | | d STREET ADDRESS 2208 Henneman Avenue | | e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First Imogene Middle Last Simms | | | | 4 DATE OF DEATH Month August Day 4 Year 1960 | | | |
| 5 SEX female | 6 COLOR OR RACE white | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH April 18, 1919 | | 9 AGE (In years last birthday) 41 yrs | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b KIND OF BUSINESS OR INDUSTRY | | 11 BIRTHPLACE (State or foreign country) Pennsylvania | | 12 CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Bennett | | | | 14. MOTHER'S MAIDEN NAME Ella Youngblood | | | |
| 15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16 SOCIAL SECURITY NO Unknown | | 17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Generalized carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma right breast, ulcerative DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 year | |
| | | | | | | 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c TIME OF INJURY Month Day, Year Hour o m p m. 19 | | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f (City or town) (County) (State) | |
| 21 I certify that (I) (this hospital) attended the deceased from May 4, 1960 to Aug. 4, 1960 that (I) (we) last saw the deceased alive on Aug. 4, 1960 , and that death occurred at 11:58 p.m. from the causes and on the date stated above | | | | | | | |
| 22a SIGNATURE Stella Wachslar | | | | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 8-4-60 | | 22b DATE SIGNED | |
| 22c PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. | | | | 22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland | | | |
| 23a BURIAL, CREMATION REMOVAL (Specify) Burial Aug. 19, 60 | | 23b DATE THEREOF | | 23c NAME OF CEMETERY OR CREMATORY H. Peters | | 23d LOCATION (City, town, or county) (State) Balto. Md | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Mandall & Son | | | | ADDRESS Co (28) | | 25a. REC'D BY REGISTRAR DATE AUG 11 '60 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE Arthur S. Fries | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

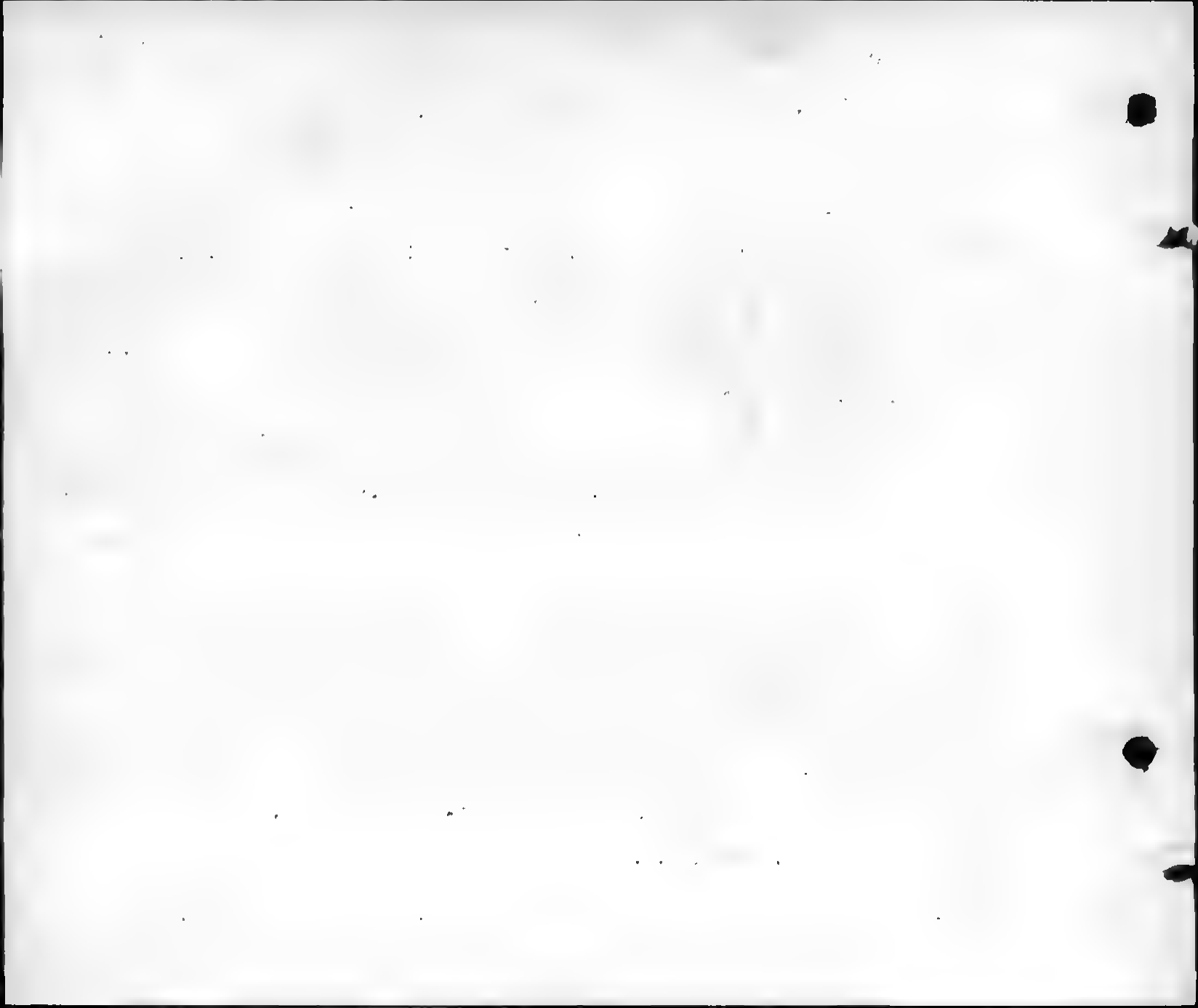
8921

CERTIFICATE OF DEATH

Reg. Dis. No. 8894

| | | | |
|---|-------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Balto. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Ma. b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevenson | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevenson | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Villa Julie | | e. STREET ADDRESS Valley Rd. | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Sister Cecilia, S.H. (Anastasia McGrath) | | 4. DATE OF DEATH Month Day Year Aug. 15, 1960 19 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 29, 1889 |
| 9. AGE (In years last birthday) yrs 71 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher—Ret | | 10b. KIND OF BUSINESS OR INDUSTRY Religious | |
| 11. BIRTHPLACE (State or foreign country) Ireland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John F. McGrath | | 14. MOTHER'S MAIDEN NAME Bridget --- | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -- | | 16. SOCIAL SECURITY NO -- | |
| INFORMANT Sister Mary Patrick— Villa Julie | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of the breast. DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 6 months 5 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 1959 to Aug 15, 1960 that I last saw the deceased alive on Aug 14, 1960 , and that death occurred at 4:30 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Harold H. Burns M.D. | | ADDRESS (Street, city or town, state) DATE SIGNED 115 East Eager Street Baltimore 2, Maryland 7-60 | |
| PHYSICIAN'S NAME (Type) Harold H. Burns, M.D. | | Baltimore 2, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 8-18-60 | 22c. NAME OF CEMETERY OR CREMATORY Trinity Convent Cem. | 22d. LOCATION (City, town, or county) (State) Ilchester, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Farley Funeral Home, Catonsville, Md. | | 24a. REC'D BY REGISTRAR DATE AUG 23 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed by the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 3 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 8922 - MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08895
Reg. Dist. No.

| | | | |
|--|----------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>CARL</u> First <u>LYNN</u> Middle <u>SIVITS</u> Last | | 4. DATE OF DEATH <u>8/27/60</u> Month <u>8</u> Day <u>27</u> Year <u>1960</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>Wh</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 6, 1934</u> |
| 9. AGE (In years last birthday) <u>26</u> yrs. | | 10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Radio Technician</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Electronics</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Johnstown, Penna.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Harry A. Sivits</u> | | 14. MOTHER'S MAIDEN NAME <u>Jennie Elva Layton</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Harry A. Sivits - New Paris, Penna.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of head, short range</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. <u>Due to</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Shot self in head</u> | |
| 20c. TIME OF INJURY Month, Day, Year <u>10 p.m. 8/27/1960</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Woods</u> | | 20f. (City or town) <u>Gunpowder Falls, Md.</u> (State) <u>Md.</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>W. Bratley King, Jr.</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>W. Bratley King, Jr.</u> | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>8/31/1960</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Fishertown Cemetery</u> | | 22d. LOCATION (City, town, or county) <u>Fishertown, Penna.</u> (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tichner & Sons - Balto. Md.</u> | | 24a. REC'D BY REGISTRAR <u>AUG 30 '60</u> DATE | |
| | | 24b. REGISTRAR'S SIGNATURE <u>L. T. Tichner</u> | |

DATE SIGNED
8/28/60



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8923

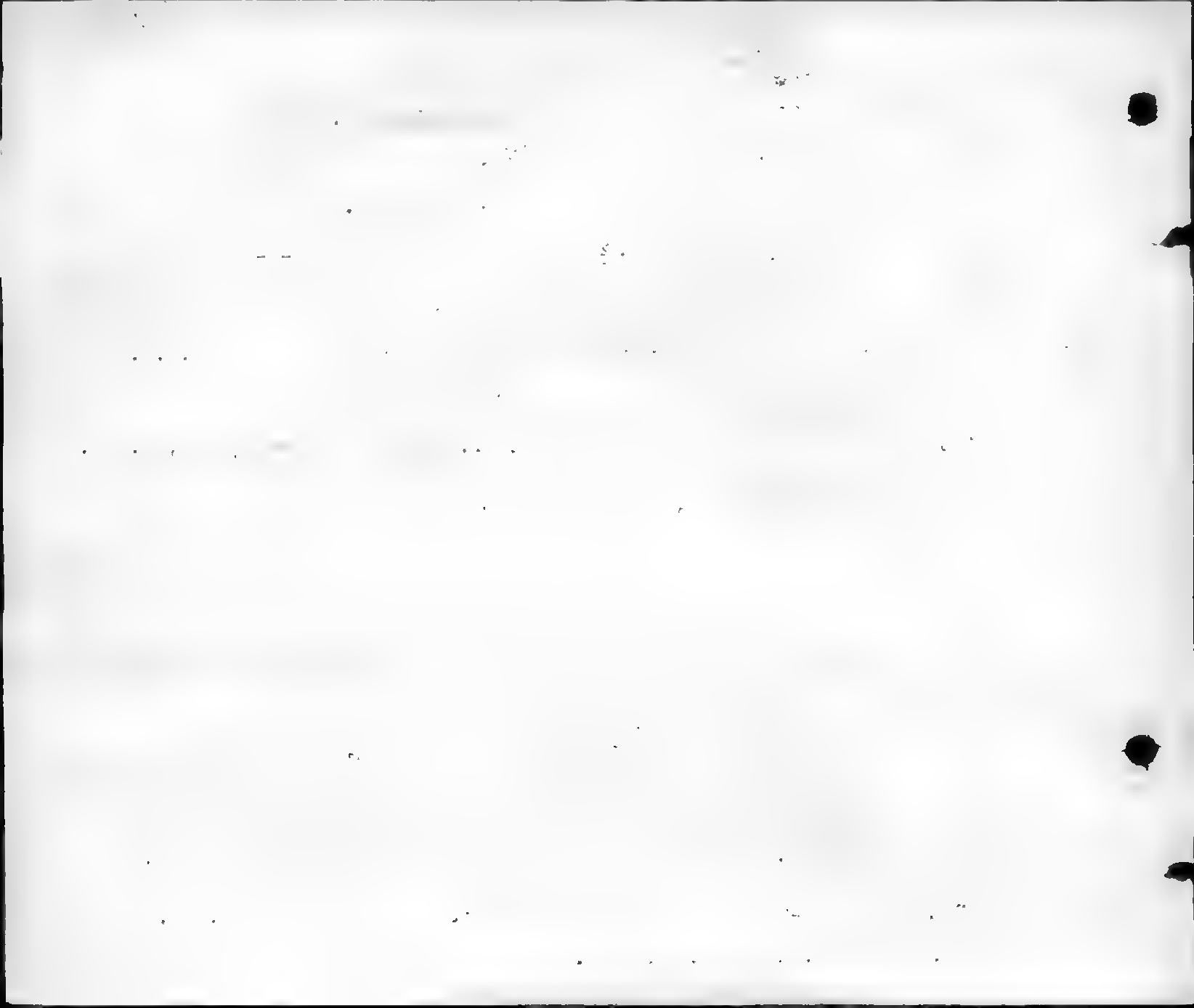
CERTIFICATE OF DEATH

08896

Reg. Dist. No.

| | | | |
|---|------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY West Virginia | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA 10 BOX 300 | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Morgantown | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Private home | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle WESLEY Last SMITH | | 4. DATE OF DEATH Month 8-6-60 Day 19 Year 19 | |
| 5. SEX Male | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept 14, 1882 |
| 9. AGE (In years last birthday) 77 yrs | | 10. IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min 77 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic | | 10b. KIND OF BUSINESS OR INDUSTRY Railroad | |
| 11. BIRTHPLACE (State or foreign country) West Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Christopher Smith | | 14. MOTHER'S MAIDEN NAME Amelia Shaw | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. Fred L. Jenkins | |
| 17. INFORMANT Fred L. Jenkins | | Address Morgantown, W. Va. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of femur = diffuse metastasis 16.7 DUE TO (b) metastasis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan 2, 1960 , to Aug 6, 1960 , that I last saw the deceased alive on Aug 6, 1960 , and that death occurred at 6:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 914 D Street, Sparrows Point DATE SIGNED 8-8-60 ACTUAL SIGNATURE John V. Conway M.D. PHYSICIAN'S NAME (Type) John V. Conway 914 D. Street, Sparrows Point, Md | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF 8-7-60 | |
| 22c. NAME OF CEMETERY OR CREMATORY Beverly Hill Memorial | | 22d. LOCATION (City, town, or county) (State) Morgantown, W. Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook Inc. L217 St. Paul St. | | 24a. REC'D BY REGISTRAR DATE AUG 9 '60 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Frank | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: At the time this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8924

CERTIFICATE OF DEATH

08897

| | | | |
|---|---------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY 1 | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | c. LENGTH OF STAY IN 1b 153 DAYS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | e. STREET ADDRESS 320 ZEPPELIN AVENUE | |
| 3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH H SMITH | | 4. DATE OF DEATH Month Day Year AUGUST 10 19 60 | |
| 5. SEX MALE | 6. COLOR OR RACE COLORED | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JULY 18, 1890 |
| 9. AGE (in years last birthday) 70 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER | | 10b. KIND OF BUSINESS OR INDUSTRY GENERAL HAULING | |
| 11. BIRTHPLACE (State or foreign country) STEELTON, PENNSYLVANIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JOSEPH SMITH | | 14. MOTHER'S MAIDEN NAME JANE KEENE | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES WWI | | 16. SOCIAL SECURITY NO. UNKNOWN | |
| 17. INFORMANT CLIN. REC. VET ADM HOSPITAL BALTO MD FT HOWARD | | Address DIVISION | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY EDEMA DUE TO ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> XXROXX ENCEPHALOMALACIA lying cause lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS, OLD. | | INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN UNKNOWN UNKNOWN | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 10 3:00 1960 to August 10 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 11 1960 , and that death occurred at P. M. from the causes and on the date stated above | | | |
| 22a. SIGNATURE FREDERICK S. DONALDSON, M.D. | | 22b. DATE 8/11/60 | |
| 22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D. | | 22d. ADDRESS VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION | |
| 23a. BURIAL CREMATION REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 8/15/60 | |
| 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL | | 23d. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Arlington S Phillips | | 25a. REC'D BY REGISTRAR AUG 15 '60 | |
| ADDRESS 1808 N Monroe St Balto Md | | 25b. REGISTRAR'S SIGNATURE C. Arthur S. Thomas | |



8925

CERTIFICATE OF DEATH

08898

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived *If institution Residence before admission) a. STATE <u>Baltimore</u> COUNTY <u>Baltimore</u> ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Catonsville</u> <u>Parade Nursing Home Md.</u> | | | | d. STREET ADDRESS <u>22 46 Wickens Ave</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>LILLIE MAY SMITH</u> | | | | 4. DATE OF DEATH Month <u>8</u> Day <u>16</u> Year <u>1960</u> | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>APRIL 6 1890</u> | |
| 9. AGE (In years last birthday) <u>70</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u> | | 11. IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>St Agnes Hospital - Sub-room work Balt. Md.</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>St Agnes Hospital - Sub-room work Balt. Md.</u> | | | |
| 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13. FATHER'S NAME <u>John S. Smith</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary M. Dean</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>212-14-1262</u> | | | |
| 17. INFORMANT <u>Mrs. Ella Rauch</u> | | | | Address <u>22 46 Wickens Ave #23</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO (c) <u>Arteriosclerotic Cardio Vascular Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkinson's Disease</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | 20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>1960</u> | | | |
| 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | | |
| 20f. (City or town) <u>Baltimore</u> | | | | 20g. (County) <u>Baltimore</u> | | | |
| 20h. (State) <u>Md.</u> | | | | 20i. (Country) <u>USA</u> | | | |
| 21. I certify that I attended the deceased from <u>1960</u> to <u>1960</u> , that I last saw the deceased alive on <u>1960</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>John M. Gerwig, Jr.</u> M.D. | | | | DATE SIGNED <u>Aug 18 1960</u> | | | |
| PHYSICIAN'S NAME (Type) <u>JOHN M. GERWIG JR</u> | | | | ADDRESS (Street, city or town, state) <u>400 Graham Rd. Balt. Md 21208</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| <u>BURIAL</u> | | <u>8-19-60</u> | | <u>London Park</u> | | <u>Baltimore Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. Walters</u> | | | | ADDRESS <u>Baltimore, Md.</u> | | | |
| 24a. REC'D BY REGISTRAR <u>Aug 18 '60</u> | | | | 24b. REGISTRAR'S SIGNATURE <u>Charles S. Harris</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

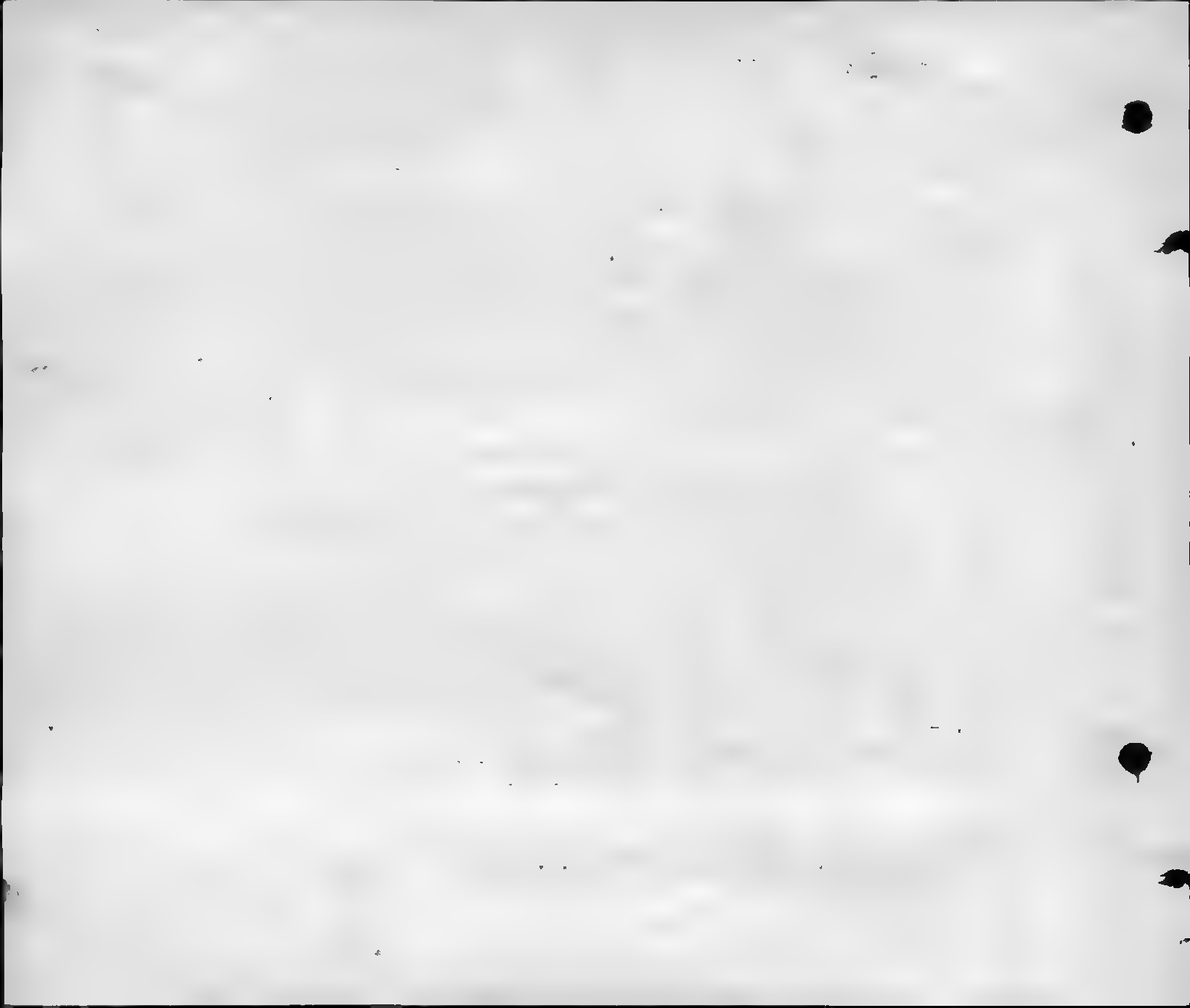
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8926 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08899

| | | | | | |
|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SPARKS c. LENGTH OF STAY IN 1b LIFE d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Road on or Cold Bottom Road | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Butler c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FALLS RD. d. STREET ADDRESS FALLS RD. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) ROBERT First E. Middle SMITH Last | | 4. DATE OF DEATH August 23 1960 Month August Day 23 Year 1960 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Colored | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHINA KEE | | 10b. KIND OF BUSINESS OR INDUSTRY STORE | | 11. BIRTHPLACE (State or foreign country) MD | |
| 13. FATHER'S NAME HARRY T. SMITH | | 14. MOTHER'S M.A.DEN NAME MILDRED LEE | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes, give war or dates of service) YES U.S. AR | | 16. SOCIAL SECURITY NO. unknown | | 17. INFORMANT Bernice Smith, 412 E. Oliver St. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head DUE TO (b) 7/16X Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) 7/16X | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in head | | | |
| 20c. TIME OF INJURY Month, Day, Year Aug. 5-6 1960 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Auto | |
| 20f. (City or town) Baltimore | | 20g. (County) B | | 20h. (State) Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE W. Bradley King, Jr., M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 8/24/60 | |
| EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D. | | M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/27/60 | | 22c. NAME OF CEMETERY OR CREMATORY Cockeysville Pk. Co. Md. | |
| 23. FUNERAL DIRECTOR Wm. L. White | | 23a. ADDRESS 1701 M. & C. Ave. | | 23b. CITY Baltimore, Md. | |
| 24a. REC'D BY REGISTRAR AUG 26 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8927

CERTIFICATE OF DEATH

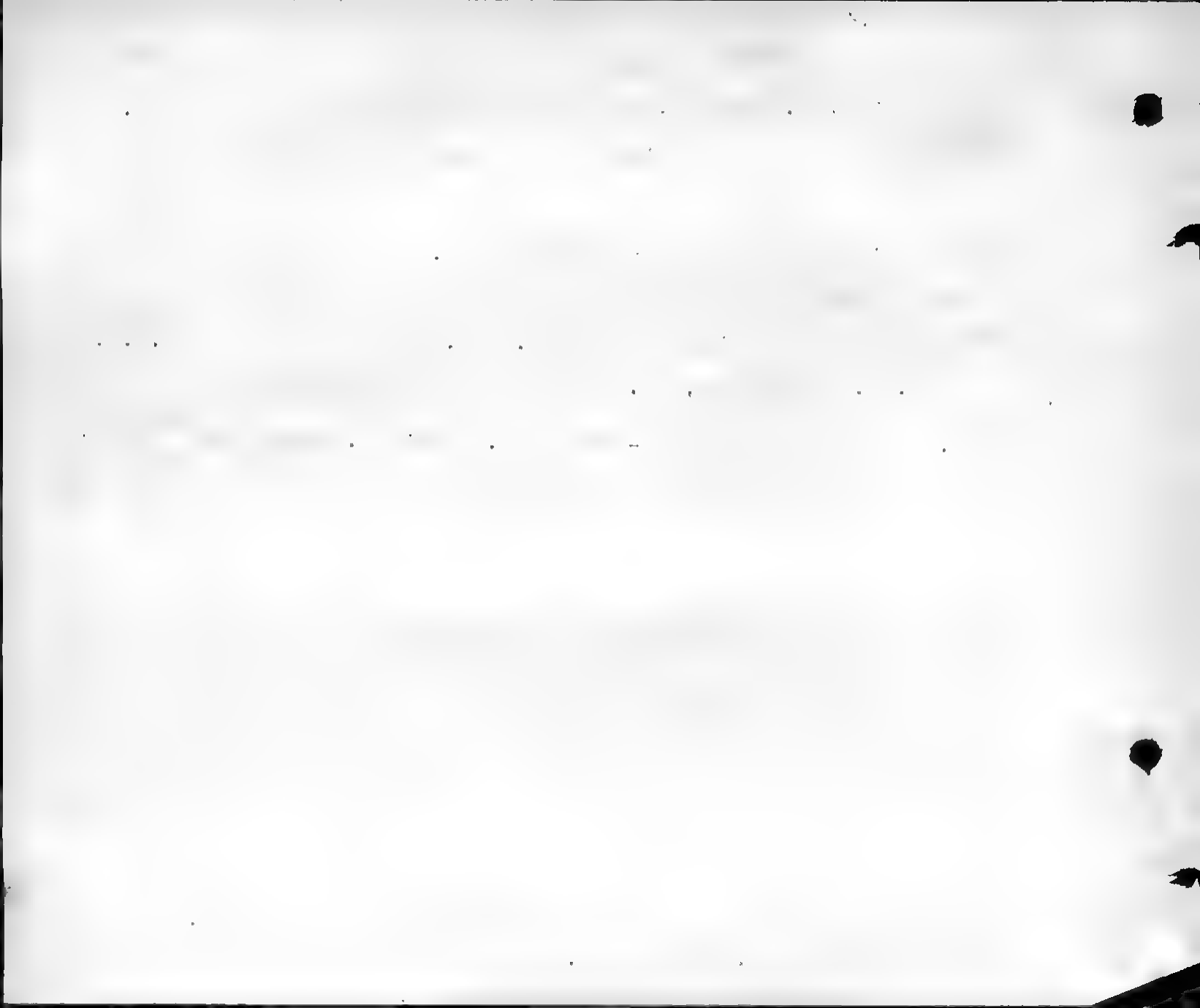
Reg. Dist. No.

08900

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore 1507 W. Joppa rd. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4 | | c. LENGTH OF STAY IN 1b Life | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First William Middle James Last Sneeringer Jr. | | 4. DATE OF DEATH * 8-21-60 Month 8 Day 21 Year 19 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9-4-1880 |
| 9. AGE (in years lost birthday) 79 yrs | | 10. IF UNDER 1 YEAR Months 7 Days 9 | 11. IF UNDER 24 HRS Hours 1 Min 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager | | 10b. KIND OF BUSINESS OR INDUSTRY Balto Trust Co. Md. | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Wm. J. Sneeringer, Sr. | | 14. MOTHER'S MAIDEN NAME ? Unlack | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No. | | 16. SOCIAL SECURITY NO. 217-14-0966 | |
| 17. INFORMANT Mrs. Hettie C. Sneeringer (wife) | | Address same as #1 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) 200.1 DUE TO cause (c), stating the underlying cause lost. (c) 200.1 | | INTERVAL BETWEEN ONSET AND DEATH 6 mos. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebrovascular disease | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 1960 to Aug 21 1960 that I last saw the deceased alive on Aug 20 1960 , and that death occurred on Aug 21 1960 M, from the causes and on the date stated above | | ADDRESS (Street, city or town, state) 100 W. University Pkwy DATE SIGNED 8/22/60 | |
| ACTUAL SIGNATURE William J. Fritz M.D. | | PHYSICIAN'S NAME (Type) W. J. Fritz | |
| 22a. BURIAL, CREMATION, REMOVAL, (Specify) Burial | | 22b. DATE THEREOF 8-23-60 | |
| 22c. NAME OF CEMETERY OR CREMATORY Gunpowder Friends Meeting | | 22d. LOCATION (City, town, or county) (State) Sparks Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Ser. 622 York Rd. Towson Md. | | 24a. REC'D BY REGISTRAR AUG 24 60 | |
| 24b. REGISTRAR'S SIGNATURE William S. Kline | | | |

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

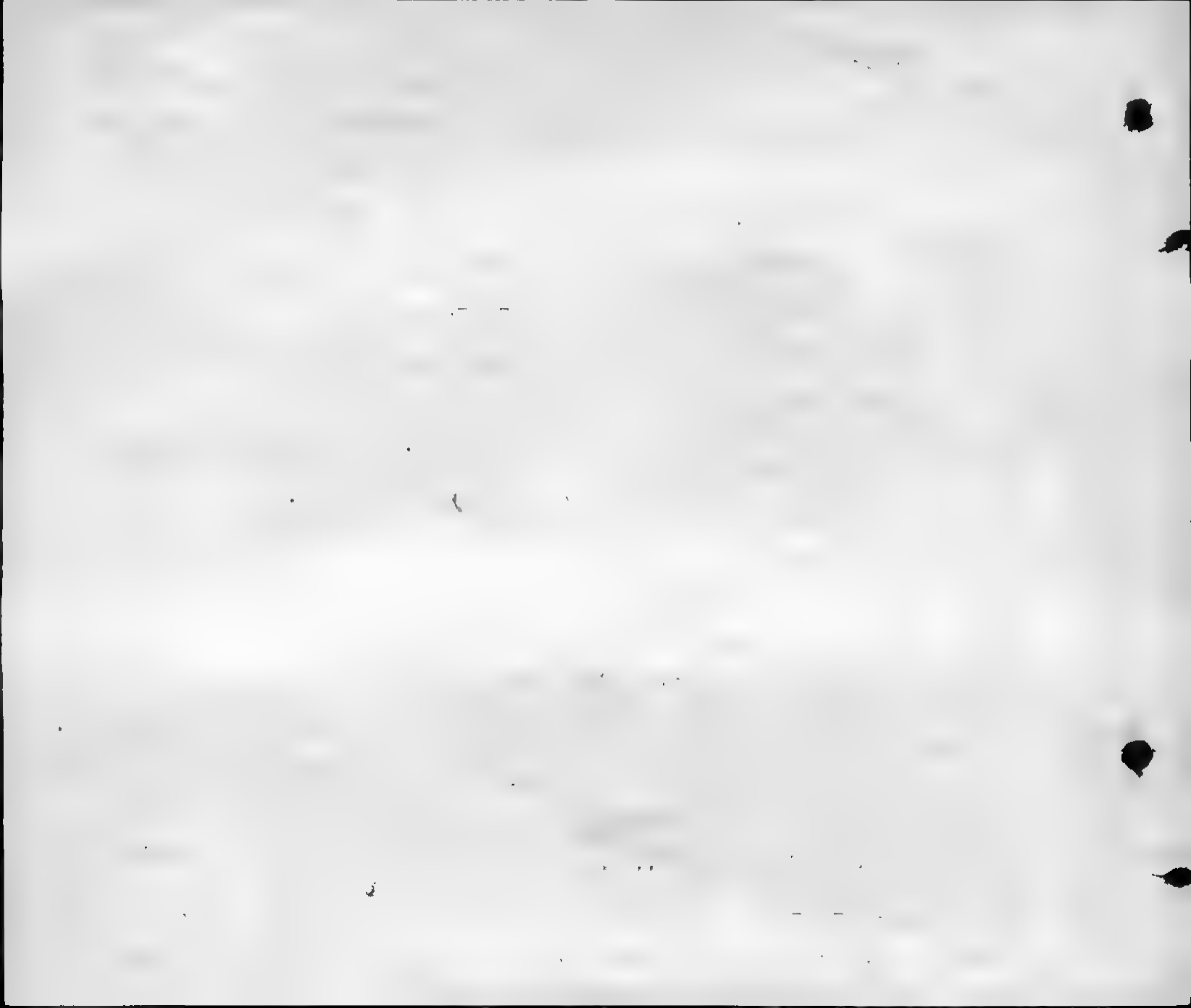
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8928

08901

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7636 Harford Rd. Wendover | | d. STREET ADDRESS 7836 Harford Road | |
| 3. NAME OF DECEASED (Type or print) Leonid SOLONSKY | | 4. DATE OF DEATH August 26 19 60 | |
| 5. SEX Male | | 6. COLOR OR RACE White | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 9-23-1922 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant Owner | | 11. BIRTHPLACE (State or foreign country) Ukraine White Russia | |
| 12. CITIZEN OF WHAT COUNTRY? Stateless | | 13. FATHER'S NAME Aphanasi Solonsky | |
| 14. MOTHER'S MAIDEN NAME Anna Amalie M. Solonsky | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of abdomen, contact type. DUE TO Conditions/ if any which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Shot self before eye witnesses | |
| 21c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 8/26/60 19 | | 21d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | |
| 21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home | | 21f. (City or town) (County) (State) Baltimore-Baltimore Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE W. Bradley King, Jr., M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 22b. DATE THEREOF 8-29-60 | |
| 22c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem. | | 22d. LOCATION (City, town, or country) (State) Baltimore, Md. | |
| 23. FUNERAL DIRECTOR Leonard B. Ruck 5305 Harford Rd. | | 24a. REC'D BY REGISTRAR AUG 30 '60 | |
| | | 24b. REGISTRAR'S SIGNATURE Charles S. Kraw | |

DATE SIGNED
August 27, 1960



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME
SM 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Parkville
c. LENGTH OF STAY IN MD
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8207 Harford Road

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Parkville
d. STREET ADDRESS 8207 Harford Road

3. NAME OF DECEASED (Type or print) HENRY SPIELMAN
4. DATE OF DEATH August 31, 1960

5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH Sept. 12, 1892 9. AGE (in years last birthday) 67 yrs. IF UNDER 1 YEAR: Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 10b. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE (State or foreign country) Balto. Co. Md. 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Spielman 14. MOTHER'S MAIDEN NAME Wilhelmina Jasper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. None 17. INFORMANT Mrs. Dora Brendel Address 8305 Harford Rd. 14

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gunshot wound of left chest
DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) (b) (c)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Shot self in chest

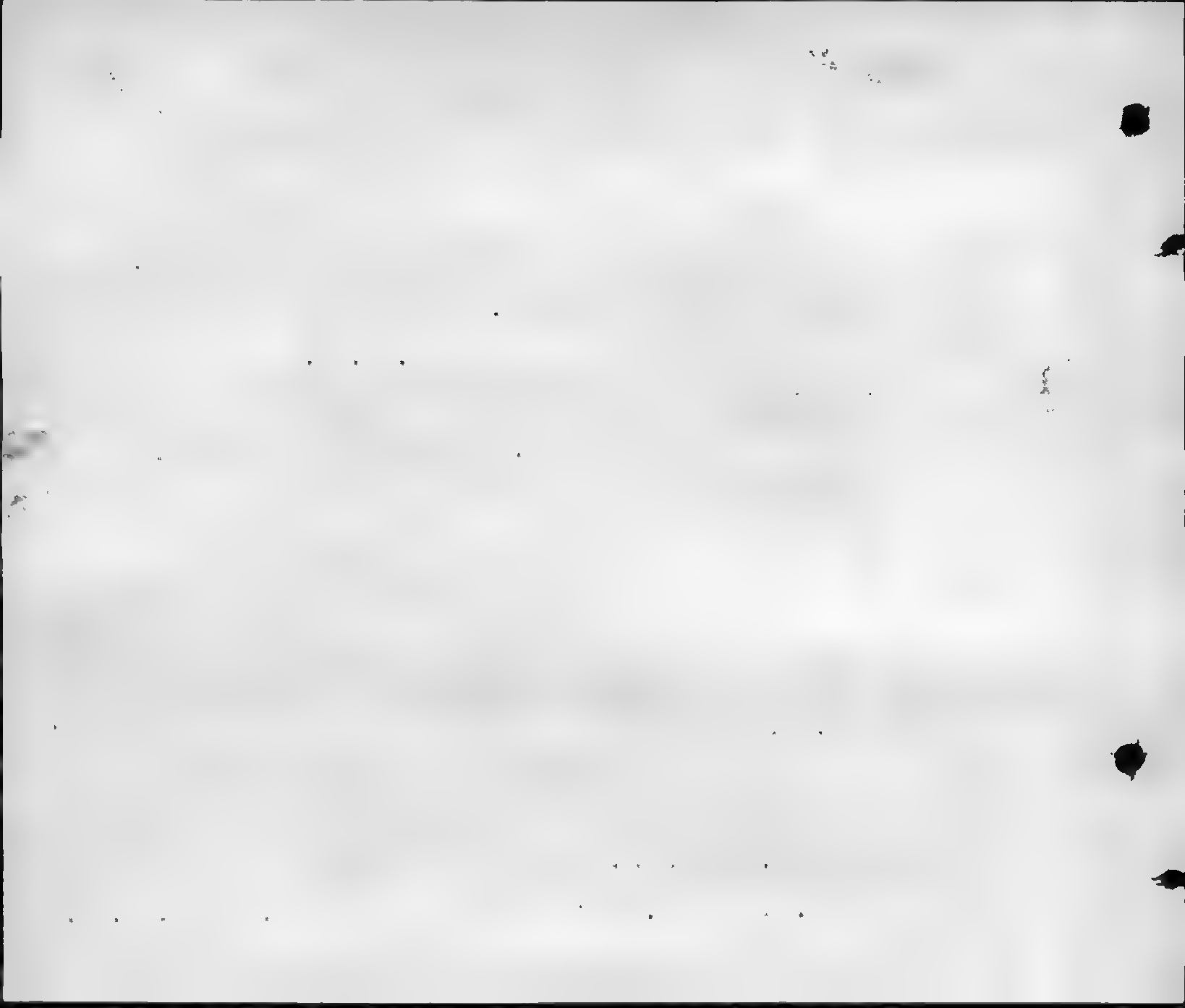
20c. TIME OF INJURY Month, Day, Year Aug. 31, 60 20d. INJURY OCCURRED While ☐ at work ☐ Not While ☒ at work ☒ 20e. PLACE OF INJURY (Home, farm, factory, store, office bldg, etc.) House 20f. (City or town) (County) (State) Baltimore, Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Russell S. Fisher M.D. CHIEF MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type) Russell S. Fisher, M.D. ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐ DATE SIGNED 8/31/60
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF Sept. 3, 1960 22c. NAME OF CEMETERY OR CREMATORY St. John's Lutheran 22d. LOCATION (City, town, or country) (State) Harford Rd. Balto. Co. Md.

23. FUNERAL DIRECTOR Samah's Funeral Home ADDRESS 7401 Belair Rd. 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Arthur L. Evans DATE SEP 2 '60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the attending physician and completely filled in by the funeral director, or
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, or
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

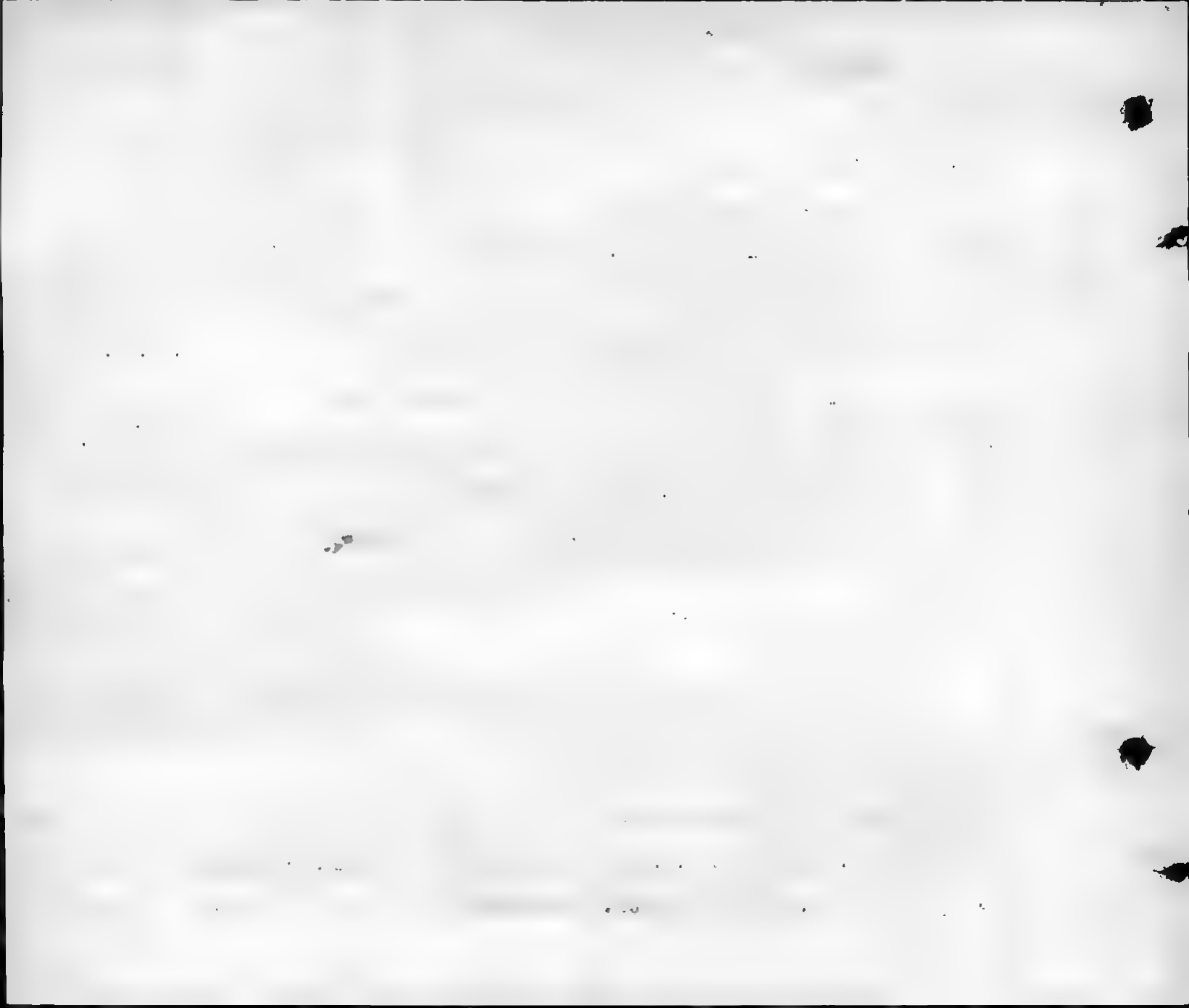
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8930

CERTIFICATE OF DEATH

08903

| | | | |
|--|------------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY — | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md. | | c. LENGTH OF STAY IN 1b 28 Days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (17) | |
| f. STREET ADDRESS 318 N. Carrollton Avenue | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First WILLIAM Middle H. Last STANSBURY | | 4. DATE OF DEATH Month August Day 24 Year 1960 | |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH February 4, 1889 |
| 9. AGE (In years last birthday) 71 yrs | | 10. IF UNDER 1 YEAR: Months — Days — Hours — Min — | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer-Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Public Schools | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME James Stansbury | | 14. MOTHER'S MAIDEN NAME Anna MN: Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I | | 16. SOCIAL SECURITY NO. 215-07-3521 | |
| 17. INFORMANT Clinical Records, VAH, Baltimore 18, Md. | | Address FORT HOWARD | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | |
| PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, BILATERAL DUE TO BRONCHOGENIC CARCINOMA, LEFT LUNG Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) METASTATIC CARCINOMA, LEFT ADRENAL AND LEFT CEREBELLAR HEMISPHERE (c) — | | | |
| INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN UNKNOWN | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Arteriosclerosis, generalized. 2. Chronic hemorrhagic cystitis. 3. Benign prostatic hypertrophy. | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour — o. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (this hospital) attended the deceased from July 27, 1960 to August 24, 1960 that (we) last saw the deceased alive on August 24, 1960 , and that death occurred at 11:00 PM , from the causes and on the date stated above | | | |
| 22a. SIGNATURE Frederick S. Donaldson M.D. | | 22b. DATE SIGNED 8/25/60 | |
| 22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D. | | 22d. ADDRESS VAH, BALTO. 18, MD. FORT HOWARD DIVISION | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Aug. 30, 1960 | |
| 23c. NAME OF CEMETERY OR CREMATORY Balto. National Cem | | 23d. LOCATION (City, town or county) (State) Baltimore Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Mrs. Katie R. Williams | | 25a. REC'D BY REGISTRAR DATE AUG 31 '60 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Kneass | | 25c. ADDRESS 322 N. Schroeder Street Baltimore, Maryland | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8931

CERTIFICATE OF DEATH

Reg. Dist. No. 08904

| | | | | | | | |
|---|--|--|--------------------------------------|---|-----------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS <u>2526 Wycliffe Road</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE</u> <u>W</u> <u>STEFFEY</u> | | | | 4. DATE OF DEATH Month Day Year <u>Aug.</u> <u>4</u> <u>1960</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct. 1871</u> | 9. AGE (In years last birthday) yrs | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief Clerk</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Court House</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Henry W. Steffey</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Caroline Williams</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT Address <u>G.H. Steffey (son) 2526 Wycliffe Rd. 14</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> <u>Cardio-vascular dis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>20 yrs</u> DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>none</u> 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u> | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1937</u> to <u>Aug. 4, 1960</u> , that I last saw the deceased alive on <u>July 21, 1960</u> , and that death occurred at <u>5 A. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2510 Taylor Ave. Baltimore - 14 - Md.</u> DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE <u>G. M. Bacon</u> M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>A. M. BACON</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>Aug. 6, 1960</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Carroll County, Md.</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wm. Cook-Towson, Inc. 1050 York Rd.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>AUG 8 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Carlton S. Hume</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

10048

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8932

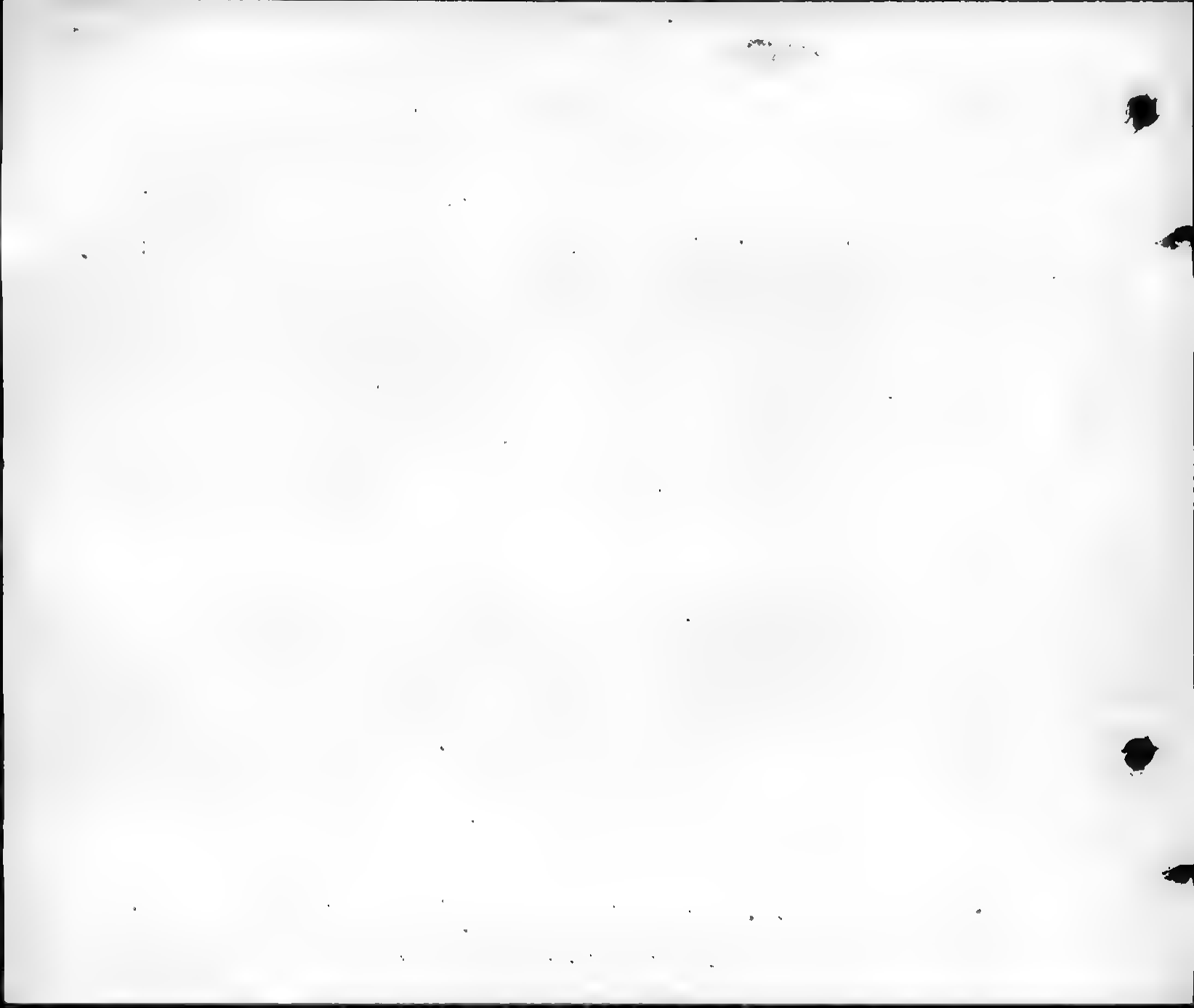
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---|---|--|
| 1 PLACE OF DEATH a. COUNTY <u>MARYLAND</u> | | 2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Frederick</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> | | c. LENGTH OF STAY IN lb <u>Yrs.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Frederick</u> | | e. STREET ADDRESS <u>1000 11th Ave.</u> | |
| 3 NAME OF DECEASED (Type or print) <u>ALICE ELIZABETH STEIGERWALD</u> | | 4. DATE OF DEATH Month <u>Aug</u> Day <u>31</u> Year <u>1960</u> | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MAY 27, 1971</u> |
| 9. AGE (In years last birthday) <u>79</u> yrs | | 10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John Wesley Palmer</u> | | 14. MOTHER'S MAIDEN NAME <u>Sarah Nease</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>1-000</u> | |
| 17. INFORMANT <u>Mrs. Esther S. Palmer</u> | | Address <u>Same</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARCINOMA OF LIVER</u> 156-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) DUE TO PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>osteoarthritis</u> | | | INTERVA. BETWEEN ONSET AND DEATH <u>?</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month. Day Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Aug 29</u> 19 <u>60</u> and that death occurred at <u>4:30</u> P. M. from the causes and on the date stated above. | | | |
| 21a. ADDRESS (Street, city or town, state) | | DATE SIGNED | |
| SIGNATURE <u>Rose M. Palmer</u> M.D. <u>Pikerville Med. Center</u> | | <u>8/31/60</u> | |
| DECEASED'S NAME (Type) <u>LOUIS Z. DALMAU</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>Sept. 1, 1960</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Frederick, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u> | | 24a. REC'D BY REGISTRAR <u>SEP 8 '60</u> | 24b. REGISTRAR'S SIGNATURE <u>William S. Hume</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



8933

CERTIFICATE OF DEATH

08905

Reg. Dist. No.

| | | | | | | | |
|---|------------------------------|--|--|--|---|--|---|
| 1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rose Dale</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rose Dale</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6518 Golden Ring Rd</u> | | | | e. STREET ADDRESS <u>6518 Golden Ring Rd</u> | | | |
| 3 NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM (MILBURN) C. STINSON</u> | | | | 4 DATE OF DEATH Month Day Year <u>Aug 10 1960</u> | | | |
| 5 SEX <u>MALE</u> | 6. COLOR OR RACE <u>W</u> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb. 24, 1891</u> | 9. AGE (In years last birthday) <u>69</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Paper Maker</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11 BIRTHPLACE (State or foreign country) <u>INDIANA</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | | | |
| 13. FATHER'S NAME <u>George STINSON</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MARY Smith</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | | 17. INFORMANT <u>Family</u> | | Address <u>Same</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Failure</u> DUE TO (b) <u>Cardiovascular Insufficiency</u> DUE TO (c) <u>Chronic Renal Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe Chronic Emphysema</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>4-29</u> , 19 <u>51</u> , to <u>8-10</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>8-10</u> , 19 <u>60</u> , and that death occurred at <u>6 P. M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL TIME <u>John G. Orth, M.D.</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Philadelphia Pa.</u> DATE SIGNED <u>8-11-60</u> | | | |
| PHYSICIAN'S NAME (Type) <u>John G. Orth, M. D.</u> | | | | Baltimore 6, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>8-13-60</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Hahn</u> | | | | ADDRESS <u>269 Lake Rd. Pasadena, Cal. MD.</u> | | 24a. REC'D BY REGISTRAR DATE <u>AUG 15 '60</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
M

| | | | |
|---|---------------------------------|---|-------------------------------------|
| 1 PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Pikesville d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6803 Wellwood Court | | 2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 4213 Granada Ave. • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) PHILIP H. STRAUSS First Middle Last | | 4. DATE OF DEATH 8/13/60 Month Day Year | |
| 5 SEX Male | 6 COLOR OR RACE White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH Sept 1893 |
| 9a. AGE (in years last birthday) 66 yrs | | 9b. FINDER 1 YEAR Months Days Hours Min. | |
| 10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector | | 10b. KIND OF BUSINESS OR INDUSTRY Dairy Products | |
| 11 BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12 CITIZEN OF WHAT COUNTRY? USA | |
| 13 FATHER'S NAME Nathan Strauss | | 14. MOTHER'S MAIDEN NAME Rosa Strauss | |
| 15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17 INFORMANT Mrs. Betty Strauss | | Address Sane | |
| 18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis of coronary artery DUE TO (c) Hypertension | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21 I certify that (I) (this hospital) attended the deceased from Mar 15, 1956 to Aug 13, 1960 , that (I) (we) last saw the deceased alive on Aug 3, 1960 , and that death occurred at 11 P. M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Daniel J. Schwartz M. D. | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22b. ADDRESS 2320 Eastwood Vt. | |
| 22c. PHYSICIAN'S NAME (Type) DANIEL J. SCHWARTZ | | 22d. DATE SIGNED 8/14/60 | |
| 23a. BURIAL CREMATION, etc. (Specify) BURIAL | | 23b. DATE THEREOF 8/15/60 | |
| 23c. NAME OF CEMETERY OR CREMATORY Hebrew Friendship | | 23d. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE SOL LEVINSON & BROS INC. 6010 Reisterstown Rd. | | ADDRESS 6010 Reisterstown Rd. | |
| 25a. REC'D BY REGISTRAR AUG 17 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Korman | |



BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8935

CERTIFICATE OF DEATH

08907

San. Dist. No.

1 NAME OF DECEASED
(Type or Print)

Henry A. Streib

2 DATE OF DEATH

Aug. 20, 1960

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

X 5 St. Michaels Way

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

A. STATE B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN

Baltimore

(If outside city limits, write RURAL and give township)

D. STREET ADDRESS

(If rural, give location)

5 St. Michaels Way

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

Feb. 12-1881

9. AGE (In years
last birthday)

79

If Under 1 Year

Months

If Under 24 Hours

Days

Hours

Min

10. A. USUAL OCCUPATION (Give kind of
work done during most of working life, even
if retired)

Retired

10b. KIND OF BUSINESS OR INDUSTRY

P.R.R. Carpenter

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Streib

14. MOTHER'S MAIDEN NAME

Margaret Nauman

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO

17. INFORMANT

ADDRESS

Mrs. Annetta Bristow 5 St. Michaels Way

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Anterior ischemic heart disease

2 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

Chronic pulmonary emphysema

5 yrs.

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT

Chronic pulmonary emphysema 3 yrs.

IF OPERATION WAS RELATED TO
CAUSE OF DEATH, ENTER IN
PART I OR PART II

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20. AUTOPSY?

YES ☐NO ☒22. I certify that (I) (this hospital) attended the deceased from June 10 - 1954 to Aug 20 1960 that (I) (we) last saw the deceased alive on Aug 18 1960 and that in (my) (our) opinion death occurred at 7:30 P.M. from the causes and on the date stated above.

23a. SIGNATURE

Leonard J. Ruck

23b. ADDRESS

4808 Harford Rd.

23c. DATE SIGNED

8/22/60

ATTENDING PHYS ☐MED. DIRECTOR ☐STAFF PHYS ☐

M. D.

24a. BURIAL, CREMATION,
REMOVAL

Burial

24b. DATE

8/23/60

24c. NAME OF CEMETERY OR CREMATORY

Baltimore

24d. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

25a. DATE REC'D BY HEALTH DEPT.

AUG 25 60

25b. NAME OF REGISTRAR

S. J. Ruck

25c. FUNERAL DIRECTOR

Leonard J. Ruck 5305 Harford Rd.

ADDRESS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

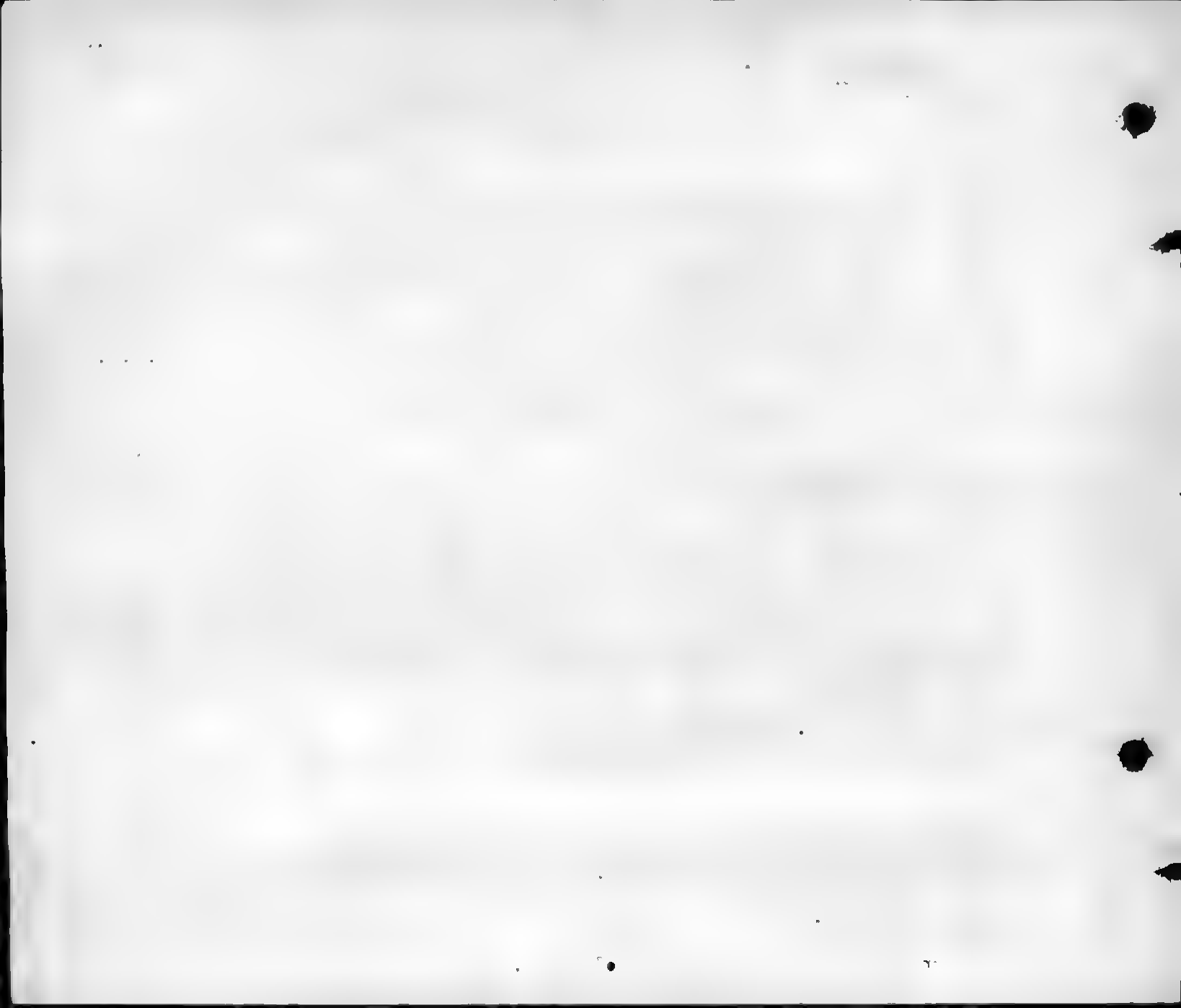
8936

Reg. Dist. No 08908

FOR STATE
HEALTH DEPT.

| | | | | | | | | | | | |
|--|--|--|--|---|-----------------|-----------------|---|---|---------------------|------------------|------------|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u> c. LENGTH OF STAY IN <u>8</u> years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rosewood Training School</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Virginia</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manassas</u> d. STREET ADDRESS <u>361 Manassas Drive</u> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>Frederick</u> Last <u>Streif</u> | | 4. DATE OF DEATH Month <u>August</u> Day <u>3</u> Year <u>1960</u> | | | | | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | | | | | | | | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>October 20, 1949</u> | | 9. AGE (In years last birthday) <u>10</u> y/s <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS</td> </tr> <tr> <td>Months Days</td> <td>Hours Min</td> </tr> </table> | | IF UNDER 1 YEAR | IF UNDER 24 HRS | Months Days | Hours Min | | | | |
| IF UNDER 1 YEAR | IF UNDER 24 HRS | | | | | | | | | | |
| Months Days | Hours Min | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>10b. KIND OF BUSINESS OR INDUSTRY</td> <td>11. BIRTHPLACE (State or foreign country)</td> <td>12. CITIZEN OF WHAT COUNTRY?</td> </tr> <tr> <td></td> <td><u>Virginia</u></td> <td><u>U.S.A.</u></td> </tr> </table> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? | | <u>Virginia</u> | <u>U.S.A.</u> | 13. FATHER'S NAME <u>Ernest Streif</u> | | | |
| 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? | | | | | | | | | |
| | <u>Virginia</u> | <u>U.S.A.</u> | | | | | | | | | |
| 14. MOTHER'S MAIDEN NAME <u>June Daniels</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> | | | | | | | | | |
| 16. SOCIAL SECURITY NO <u>None</u> | | 17. INFORMANT <u>Records at Rosewood Owings Mills, Maryland</u> | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Failure - due to strangulation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Caused by foreign body in trachea - small apple</u> DUE TO (c) <u>Congenital cerebral Epilepsy - Grand Mal</u> | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased choked on apple.</u> | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year <u>2:15</u> a.m. <u>Aug. 3, 1960</u> p.m. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>20d. INJURY OCCURRED</td> <td>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</td> <td>20f. (City or town)</td> <td>(County)</td> <td>(State)</td> </tr> <tr> <td>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></td> <td><u>Rosewood School</u></td> <td><u>Owings Mills</u></td> <td><u>Baltimore</u></td> <td><u>Md.</u></td> </tr> </table> | | 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | <u>Rosewood School</u> | <u>Owings Mills</u> | <u>Baltimore</u> | <u>Md.</u> |
| 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | | | | | | |
| While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | <u>Rosewood School</u> | <u>Owings Mills</u> | <u>Baltimore</u> | <u>Md.</u> | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Clarence E. McWilliams</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | |
| EXAMINER'S NAME (Type) <u>Clarence E. McWilliams, M.D. Acting</u> | | DATE SIGNED <u>August 3, 1960</u> | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Aug. 6, 1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u> | | | | | | | |
| 22d. LOCATION (City, town, or county) <u>Annapolis, Maryland</u> | | 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u> | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Howe Ing Funeral Home</u> | | ADDRESS <u>Annapolis, Md.</u> | | DATE <u>AUG 8 '60</u> | | | | | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8937

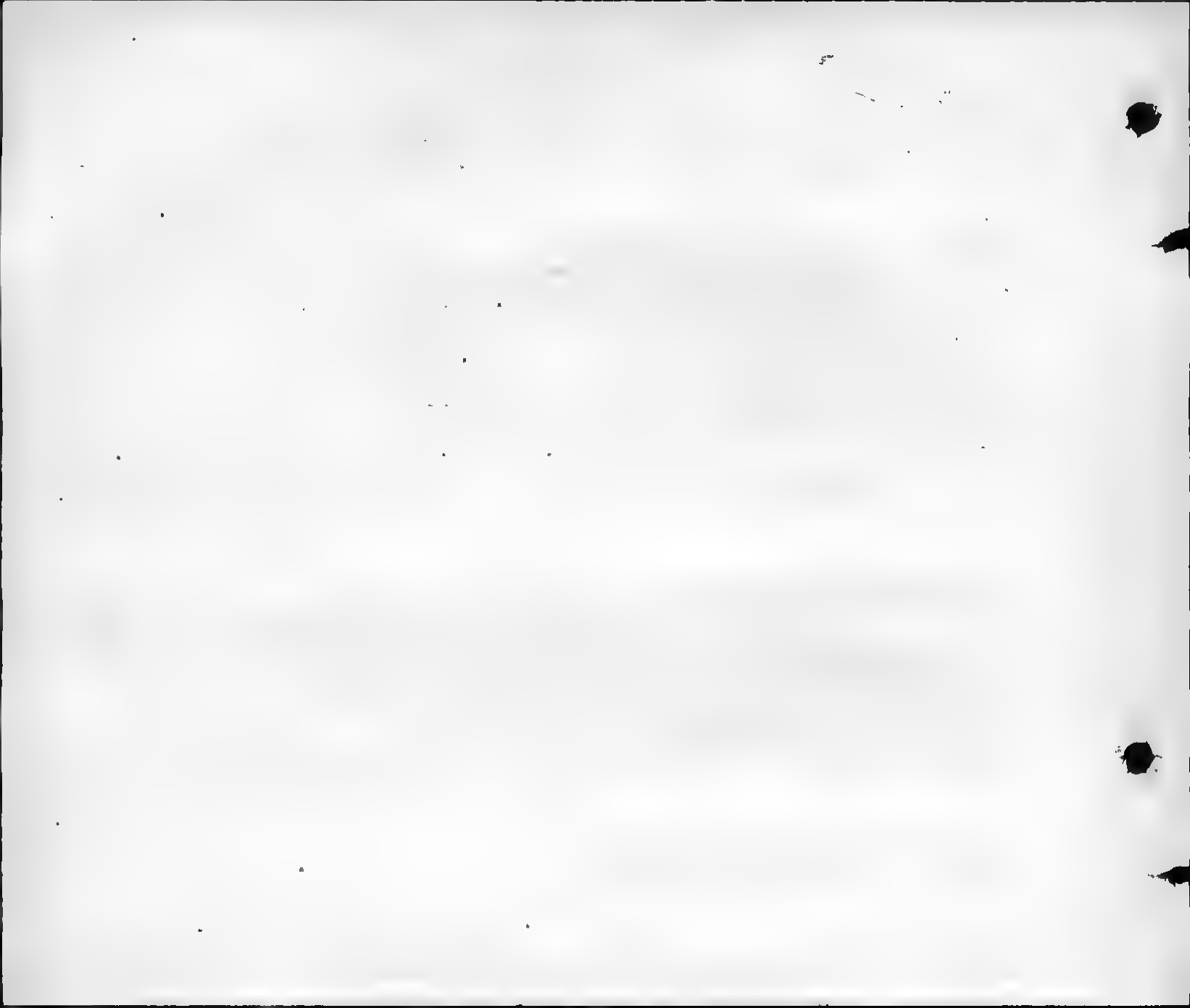
CERTIFICATE OF DEATH

Reg. Dist. No.

08999

| | | | |
|---|--|--|---|
| 1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glendale Baltimore</u> | | c. LENGTH OF STAY IN 1b <u>1 1/2 yrs</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6742 Glenkirk Rd</u> | | d. STREET ADDRESS <u>6742 Glenkirk Rd.</u> | |
| 3 NAME OF DECEASED (Type or print) First Middle Last <u>Sarah Elizabeth Summers</u> | | 4 DATE OF DEATH Month Day Year <u>August 13 1960</u> | |
| 5 SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct. 7, 1884</u> |
| 9 AGE (In years last birthday) <u>75</u> yrs. | | IF UNDER 1 YEAR: Months Days Hours Min. | IF UNDER 24 HRS: Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u> | 11 BIRTHPLACE (State or foreign country) <u>Md.</u> |
| 12 CITIZEN OF WHAT COUNTRY | | 13 FATHER'S NAME <u>William Ricks</u> | |
| 14 MOTHER'S MAIDEN NAME <u>Mary --</u> | | 15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | |
| 16 SOCIAL SECURITY NO <u>no</u> | | 17 INFORMANT Address <u>Mr. Harry R. Summers - 6742 Glenkirk Rd.</u> | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>331X</u> DUE TO (b) <u>Myofibrillar contractile sclerotic vascular disease</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>over 10 yrs</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension Mellitus</u> | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>1950</u> to <u>August 13, 1960</u> , that I last saw the deceased alive on <u>Aug 13, 1960</u> , and that death occurred at <u>6:15 PM</u> , from the causes and on the date stated above | | | |
| ACTUAL SIGNATURE <u>Walter T. Kees</u> M.D. | | ADDRESS (Street, city or town, state) <u>Cockeysville 13 August 1960</u> | |
| PHYSICIAN'S NAME (Type) <u>WALTER T. KEES</u> | | <u>Maryland</u> <u>1960</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>8/16/60</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u> | 22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Dickerson & Sons - Baltimore</u> ADDRESS <u>17th Rd.</u> | | 24a. REC'D BY REGISTRAR <u>Aug 15 '60</u> | 24b. REGISTRAR'S SIGNATURE <u>William J. Dickerson</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

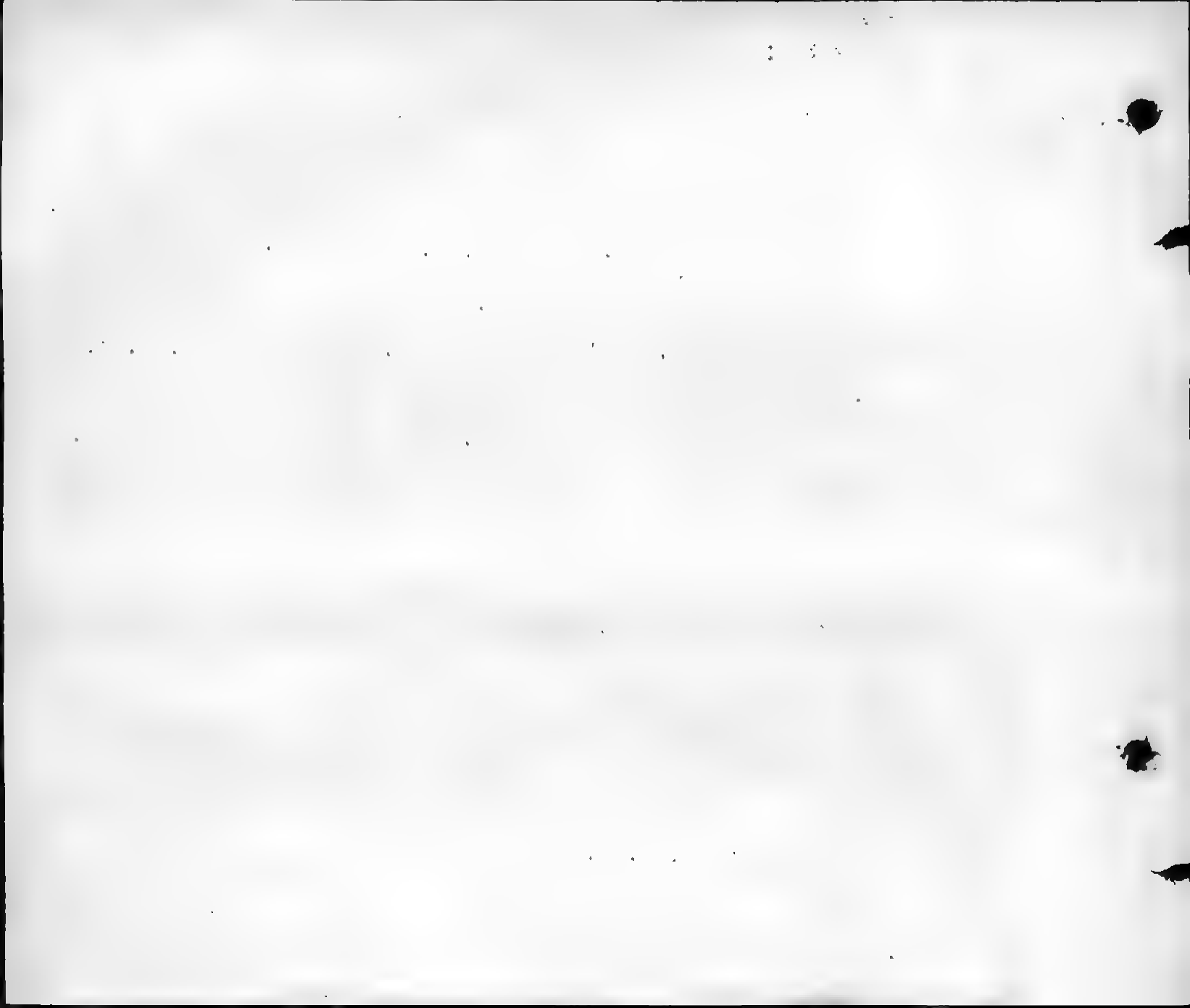
VR A15 (4)
ISM 9/59

8938

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08910

| | | | |
|---|---------------------------------|---|---|
| 1 PLACE OF DEATH a COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a STATE MD. b COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | c. LENGTH OF STAY IN 1b Maryland | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4414 Hillside Avenue | | d STREET ADDRESS 4414 Hillside Avenue | |
| e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3 NAME OF DECEASED (Type or print) First Bernard Middle J. Last Sweeting, Sr. | | 4 DATE OF DEATH Month August Day 17 , Year 1960 | |
| 5 SEX male | 6 COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH Dec. 23, 1896 |
| 9. AGE (In years last birthday) 63 yrs. | | IF UNDER 1 YEAR Months 63 Days 0 Hours 0 Min 0 | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian | | 10b KIND OF BUSINESS OR INDUSTRY Balto. Nat'l Bank Maryland | |
| 11. BIRTHPLACE (State or foreign country) U. S. A. | | 12 CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13 FATHER'S NAME Thomas B. Sweeting | | 14. MOTHER'S MAIDEN NAME Mary Davidson | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16 SOCIAL SECURITY NO. 718-10-5872 | |
| 17 INFORMANT Emma C. Sweeting | | Address 4414 Hillside Ave. #29 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.1 DUE TO Cerebral hemorrhage Conditions if any which gave rise to immediate cause (a), stating the underlying cause last. (b) Anterior-superior C.P. Hemiparesis DUE TO 10 years (c) 15 years | | INTERVAL BETWEEN ONSET AND DEATH 1 day | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 15 years | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a m p m 19 | | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Aug 17, 1960 to Aug 17, 1960 that (I) (we) last saw the deceased alive on Aug 17, 1960 and that death occurred at 19 M, from the causes and on the date stated above. | | | |
| 22a SIGNATURE John F. Coolahan M.D. | | 22b DATE SIGNED 8/17/60 | |
| 22c PHYSICIAN'S NAME (Type) John Coolahan, M. D. | | 22d ADDRESS 4201 Wilkens Ave. #29 | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8/20/60 | |
| 23c NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | 23d LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard | | 25a. REC'D BY REGISTRAR 4107 Wilkens Avenue | |
| 25b. REGISTRAR'S SIGNATURE August 18, 1960 | | 25c. REGISTRAR'S SIGNATURE August 18, 1960 | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

VR A15 (4)
ISM 9/59

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|------------------------------|---|---|--|---|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND | | | | | | | | | |
| 8939 CERTIFICATE OF DEATH 08911 | | | | | | | | | |
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | | 2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | c. LENGTH OF STAY IN 1b Months | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in Pines | | | | | d. STREET ADDRESS 1705 Belt St. | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle H. Last THOMPSON | | | | | 4. DATE OF DEATH Month 8 Day 7 Year 1960 | | | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH OCT. 18, 1876 | | 9. AGE (In years last birthday) 83 yrs | | 10. IF UNDER 1 YEAR Months 7 Days 19 Hours 60 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) B & O RR | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) GEORGIA | | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME UNK. | | | | | 14. MOTHER'S MAIDEN NAME UNK. | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown. If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Family | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Artery Disease DUE TO Hypertensive Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis (c) Chronic Nephritis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Chronic Nephritis INTERVAL BETWEEN ONSET AND DEATH 7 days per 70 | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour 19 p. m. | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from May 1960 to Aug. 7, 1960 , that (I) (we) last saw the deceased alive on 7/27/60 , and that death occurred at 1960 M, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE WALTER KOBIN | | | | | 22b. DATE SIGNED | | | | |
| 22c. PHYSICIAN'S NAME (Type) WALTER KOBIN | | | | | 22d. ADDRESS 162 E. FORT AVE. BALTO. 30 MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE THEREOF 8/11/60 | | 23c. NAME OF CEMETERY OR CREMATORY Westview Com. | | 23d. LOCATION (City, town, or county) (State) Atlanta, Georgia | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE McGully Funeral Homes | | | | | 25a. REC'D BY REGISTRAR DATE AUG 10 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Harris | | |

1

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8940

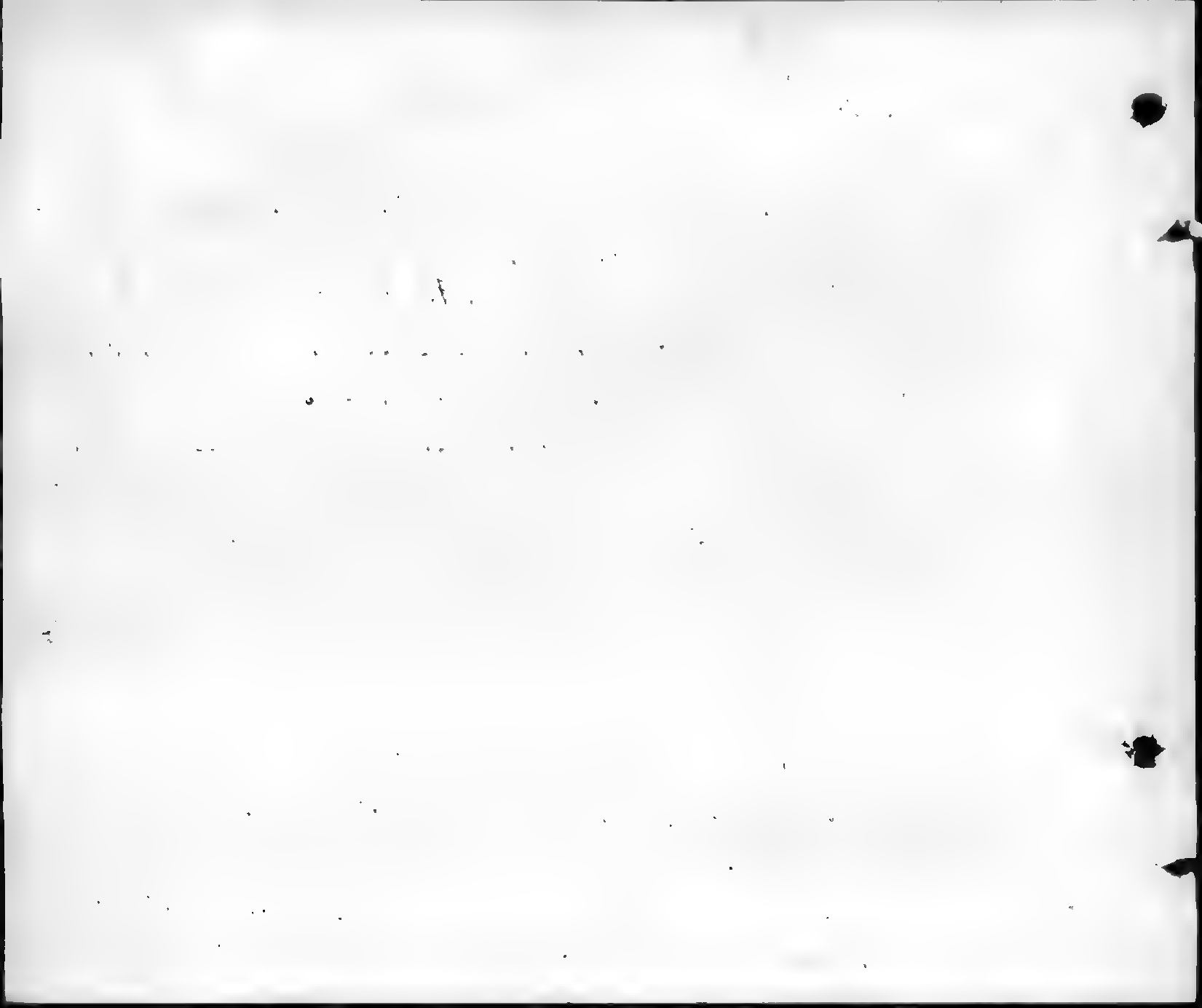
CERTIFICATE OF DEATH

08912

Reg. Dist. No

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Overlea</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Overlea</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>6800 Linden Ave. Zone 6,</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <i>Charles Emerson Tinker Jr.</i> | | 4. DATE OF DEATH Month Day Year <i>August 7, 19 60</i> | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Sept. 18, 1906</i> |
| 9. AGE (In years last birthday) <i>53</i> yrs | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Gas & Elec. Co.</i> | | 11. BIRTHPLACE (State or foreign country) <i>Balto., Md.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | |
| 13. FATHER'S NAME <i>Charles Emerson Tinker Sr.</i> | | 14. MOTHER'S MAIDEN NAME <i>Rose L. Moran</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i> | | 16. SOCIAL SECURITY NO <i>215-09-9203</i> | |
| 17. INFORMANT <i>Mrs. Eliz. Tinker</i> | | Address <i>6800 Linden Ave.</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>420-1</i> DUE TO <i>Coronary Thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <i>Atherosclerotic Cardio-Vascular Disease</i> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs.</i> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>June 24, 19 60</i> to <i>August 7, 19 60</i> that I last saw the deceased alive on <i>August 7, 19 60</i> and that death occurred at <i>7:58 PM</i> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Walter E. James</i> M.D. | | ADDRESS (Street, city or town, state) <i>5550 Baltimore National Pike</i> | |
| PHYSICIAN'S NAME (Type) <i>Walter E. James, M.D.</i> | | DATE SIGNED <i>8/7/60</i> | |
| 22a. BLR AL CREMATION REMOVAL (Specify) | | 22b. DATE HEREOF <i>8/10/60</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Garden of Earth</i> | | 22d. LOCATION (City, town, or county) (State) <i>Balto Md</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruak</i> | | 24a. REC'D BY REGISTRAR DATE <i>AUG 9 '60</i> | |
| 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

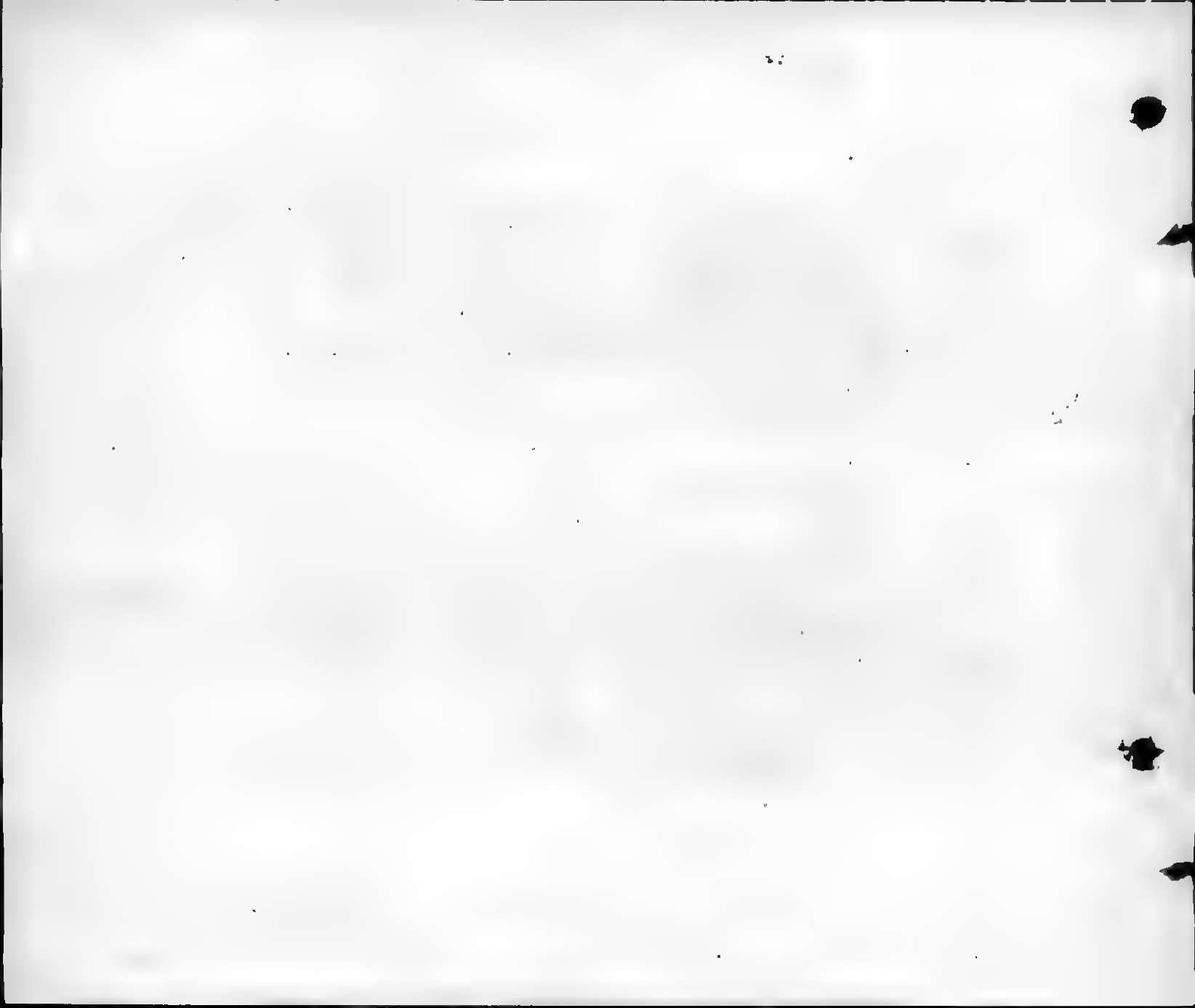
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08913

| | | | | | | | |
|---|-------------------------------|--|--------------------------------------|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrison | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Foxleigh Nursing Home | | | | d. STREET ADDRESS Temple Garden Apts Madison Avenue 15 RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 3. NAME OF DECEASED (Type or print) First SOPHIA Middle TOBIAS Last | | | | 4. DATE OF DEATH Month August Day 27 Year 1960 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 2, 1910 | | 9. AGE (In years lost birthday) 50 yrs | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary | | 10b. KIND OF BUSINESS OR INDUSTRY Public School Sy. | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Moses Tobias | | | | 14. MOTHER'S MAIDEN NAME Anna ? | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Mr. Abraham Tobias- Temple Garden Apts. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Pericard E Myocardia to the diaphragm and Regional Lymph Nodes and Abdominal Aorta Conditions if any which gave rise to immediate cause (a), stating the underlying cause last. (b) Dehydration and Secondary Anaemia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (c) Dehydration and Secondary Anaemia | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Feb. 28, 1959 to Aug 27, 1960 that (I) (we) last saw the deceased alive on Aug 27, 1960 and that death occurred at 4:45 PM from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE A. William Primakoff M.D. | | | | 22b. DATE SIGNED Aug. 28, 1960 | | | |
| 22c. PHYSICIAN'S NAME (Type) A. WILLIAM PRIMAKOFF | | | | 22d. ADDRESS EMERSONIAN APTS. BALTO. MD. | | | |
| 23a. BURIAL CREMATION REMOVAL (Specify) Burial | | 23b. DATE THEREOF Aug 29/60 | | 23c. NAME OF CEMETERY OR CREMATORY Hebrew Friendship | | 23d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Sol. Levinson & Bros. Inc. 6010 Reist Road | | | | 25a. REC'D BY REGISTRAR SEP 1 '60 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Hines | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

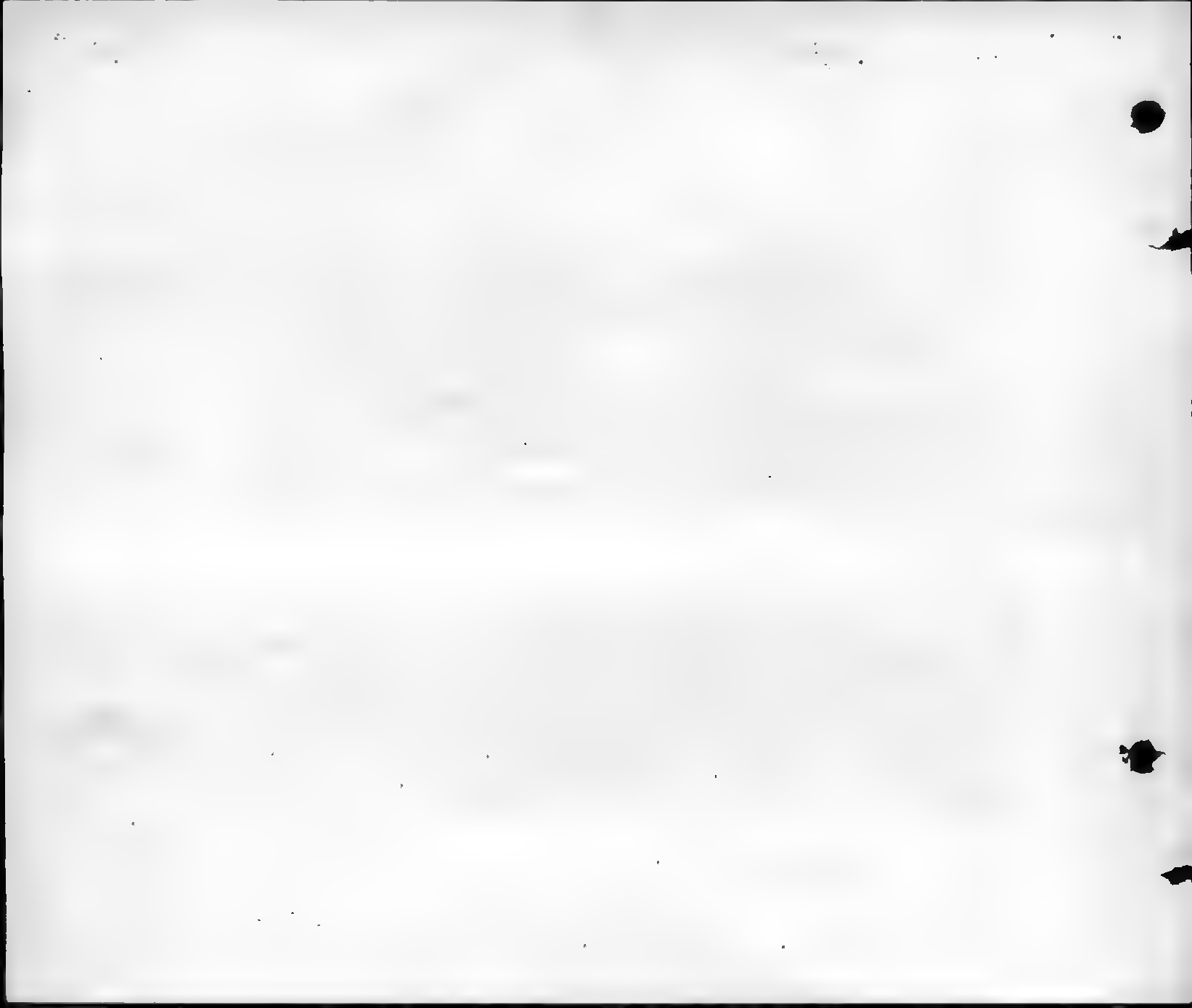
CERTIFICATE OF DEATH

8942

08914

| | | | |
|--|---------------------------------|--|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived If institut an Residence before adm'ssion) a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 18yr8mth23dys | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| f. STREET ADDRESS 2548 Robb Street | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First Myrtle Middle Last Townsend | | 4. DATE OF DEATH Month August Day 25 Year 1960 | |
| 5 SEX female | 6 COLOR OR RACE white | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8 DATE OF BIRTH March 4, 1901 |
| 9 AGE (In years last birthday) yrs 59 | | FUNDER 1 YEAR Months Days Hours Min | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b KIND OF BUSINESS OR INDUSTRY | |
| 11 BIRTHPLACE (State or foreign country) Maryland | | 12 CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME William Michell | | 14. MOTHER'S MAIDEN NAME Myrtle McKinnon | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease T22.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gangrenous decubitus ulcers 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year Hour a m. p m. 19 | | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | | 20f (City or town) (County) (State) | |
| 21 I certify that (I) (this hospital) attended the deceased from July 1, 1955 to Aug. 25, 1960 that (I) (we) last saw the deceased alive on Aug. 25, 1960 and that death occurred at 3:38 P.M. from the causes and on the date stated above | | | |
| 22a SIGNATURE Stella Wachsler | | 22b DATE SIGNED Aug. 25, 1960 | |
| 22c PHYSICIAN'S NAME (Type) Stella Wachsler, M. D. | | 22d ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland | |
| 23a BURIAL CREMATION, REMOVAL (Specify) | 23b DATE THEREOF | 23c NAME OF CEMETERY OR CREMATORY | 23d LOCATION (City, town, or county) (State) |
| Burial | 8-26-60 | Baltimore Cemetery | Baltimore Maryland. |
| 24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook Blight Inc. 6009 Harford Rd. Balto. 14 | | 25a REC'D BY REG STRAR DATE AUG 29 '60 | |
| 25b REGISTRAR'S SIGNATURE Chas S. Hume | | | |

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08915

Reg. Dist. No.

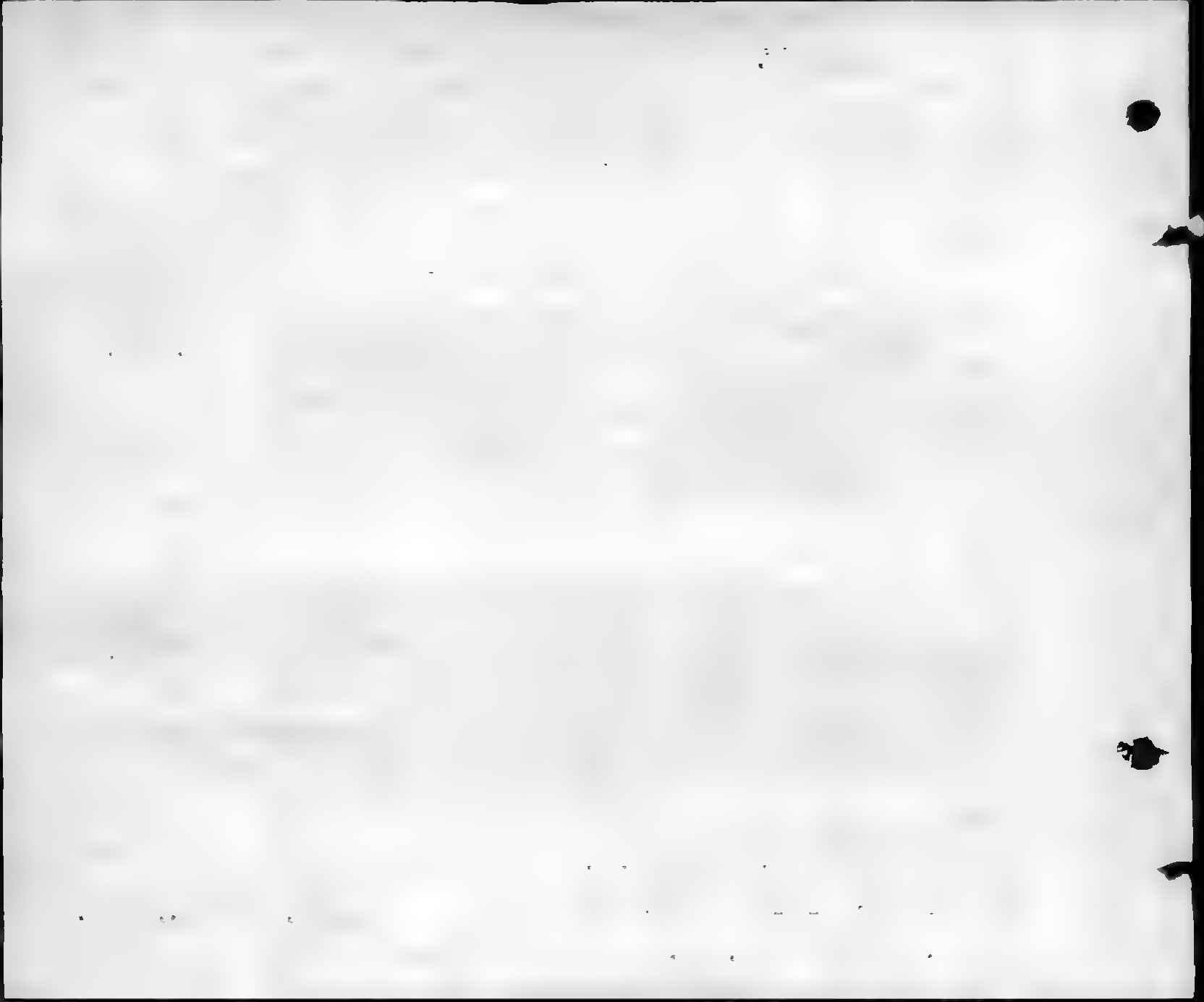
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|--|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b lyr1ldays | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| 3. NAME OF DECEASED (Type or print) First Elizabeth Middle Catherine Last Trexler | | f. STREET ADDRESS 3805 Parkview Avenue | |
| 4. DATE OF DEATH Month August Day 12 Year 1960 | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1882 July 30, 1882 |
| 9. AGE (In years last birthday) 79 78 yrs. | | 10. IF UNDER 1 YEAR Months 13 Days 13 Hours 13 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | |
| 11. BIRTHPLACE (State or foreign country) Indiana | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME XXXXXXXX Edmund Jeffries | | 14. MOTHER'S MAIDEN NAME XXXXXXXX Kate Malone | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown | | 16. SOCIAL SECURITY NO. unknown | |
| 17. INFORMATION Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia DUE TO (b) Generalized arteriosclerosis DUE TO (c) Intertrochanteric fracture of left femur 936.7 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) On 7-12-60 pt. was pushed down by another patient, striking left hip and sustaining intertrochanteric fracture of left femur | |
| 20c. TIME OF INJURY Month, Day, Year 6:35 a.m. 7-12 1960 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital | |
| 20f. (City or town) Catonsville | | (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE George M. Kieffer, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | DATE SIGNED 8-12-60 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial | | 22b. DATE THEREOF 8-12-60 | |
| 22c. NAME OF CEMETERY OR CREMATORY Mertztown Cemetery | | 22d. LOCATION (City, town, or county) (State) Longsawp, Burke Co., Penna. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons, Inc. 1900 Eutaw Place | | 24a. REC'D BY REGISTRAR AUG 15 '60 | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE Arthur L. Haud | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, use appropriate the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

(M)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

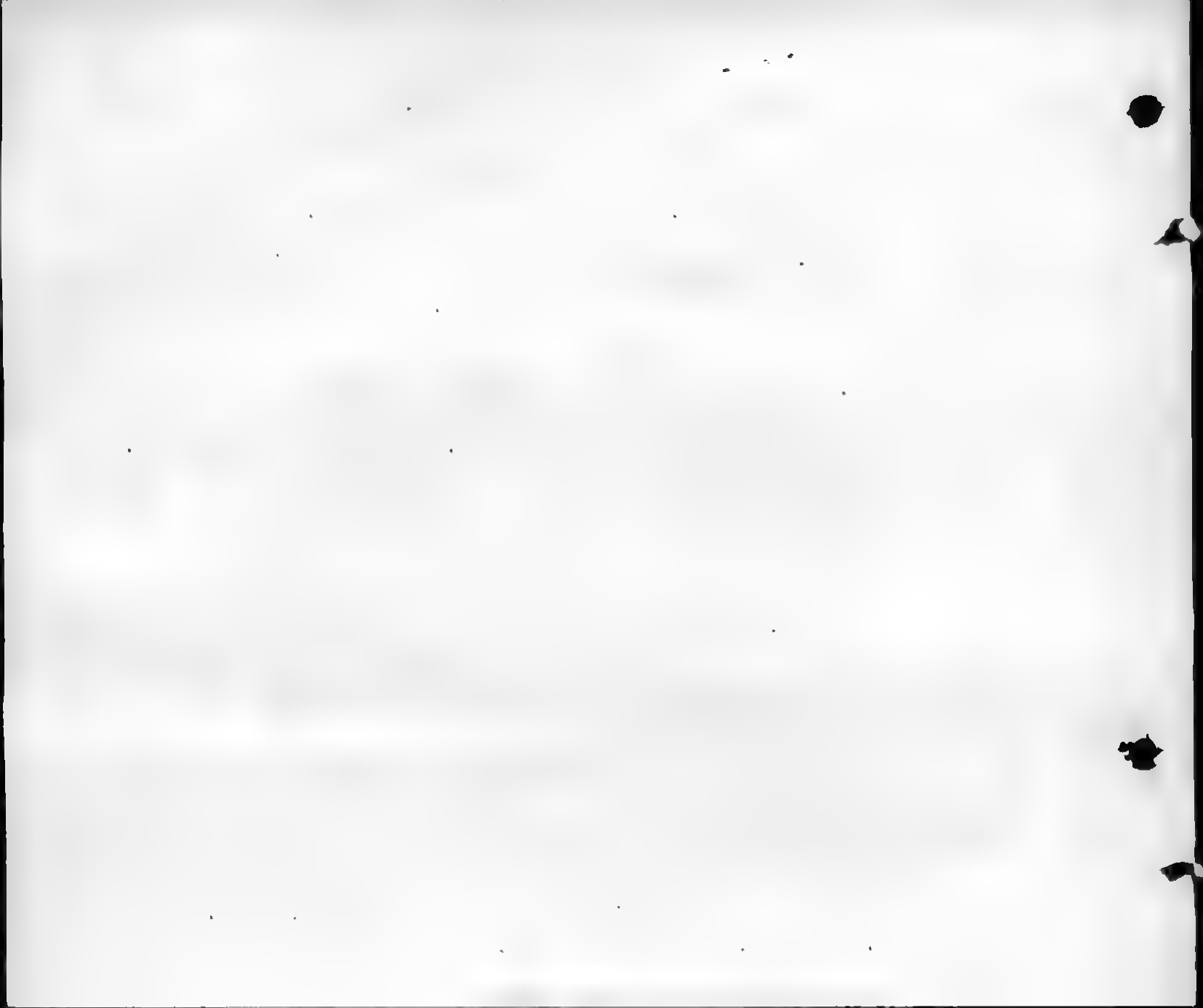
VR 115 (4)
ISM 9/59

8800 **MARYLAND STATE DEPARTMENT OF HEALTH**
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08916

| | | | |
|---|----------------------------------|---|---|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4201 Fordham Rd. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Ella M. Turner | | 4. DATE OF DEATH Month Day Year 8/21/60 19 | |
| 5 SEX Female | 6. COLOR OR RACE White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH July 25, 1871 |
| 9 AGE (In years lost birthday) yrs 89 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | |
| 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11 BIRTHPLACE (State or foreign country) Iowa | |
| 12 CITIZEN OF WHAT COUNTRY? | | 13 FATHER'S NAME Robert B. Frye | |
| 14 MOTHER'S MAIDEN NAME Katherine Teaple | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) none | |
| 16 SOCIAL SECURITY NO. none | | 17 INFORMANT Thelma C. Wells, #201 Fordham Rd. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma Liver 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Serility | | INTERVAL BETWEEN ONSET AND DEATH 8 yrs. | |
| 19 WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from Aug 1, 1960 to Aug 21, 1960 , that (I) (we) last saw the deceased alive on Aug 20 1960 , and that death occurred at 2:30 AM , from the causes and on the date stated above. | |
| 22a. SIGNATURE A. Bradley Langharty | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8/25/60 | |
| 23c. NAME OF CEMETERY OR CREMATORY Mountain View Cemetery | | 23d. LOCATION (City, town, or county) (State) Pueblo, Colo. | |
| 24 FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard, 4107 Wilkens Ave. | | 25a. REC'D BY REGISTRAR DATE AUG 23 '60 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Harris | | | |

MEDICAL CERTIFICATION



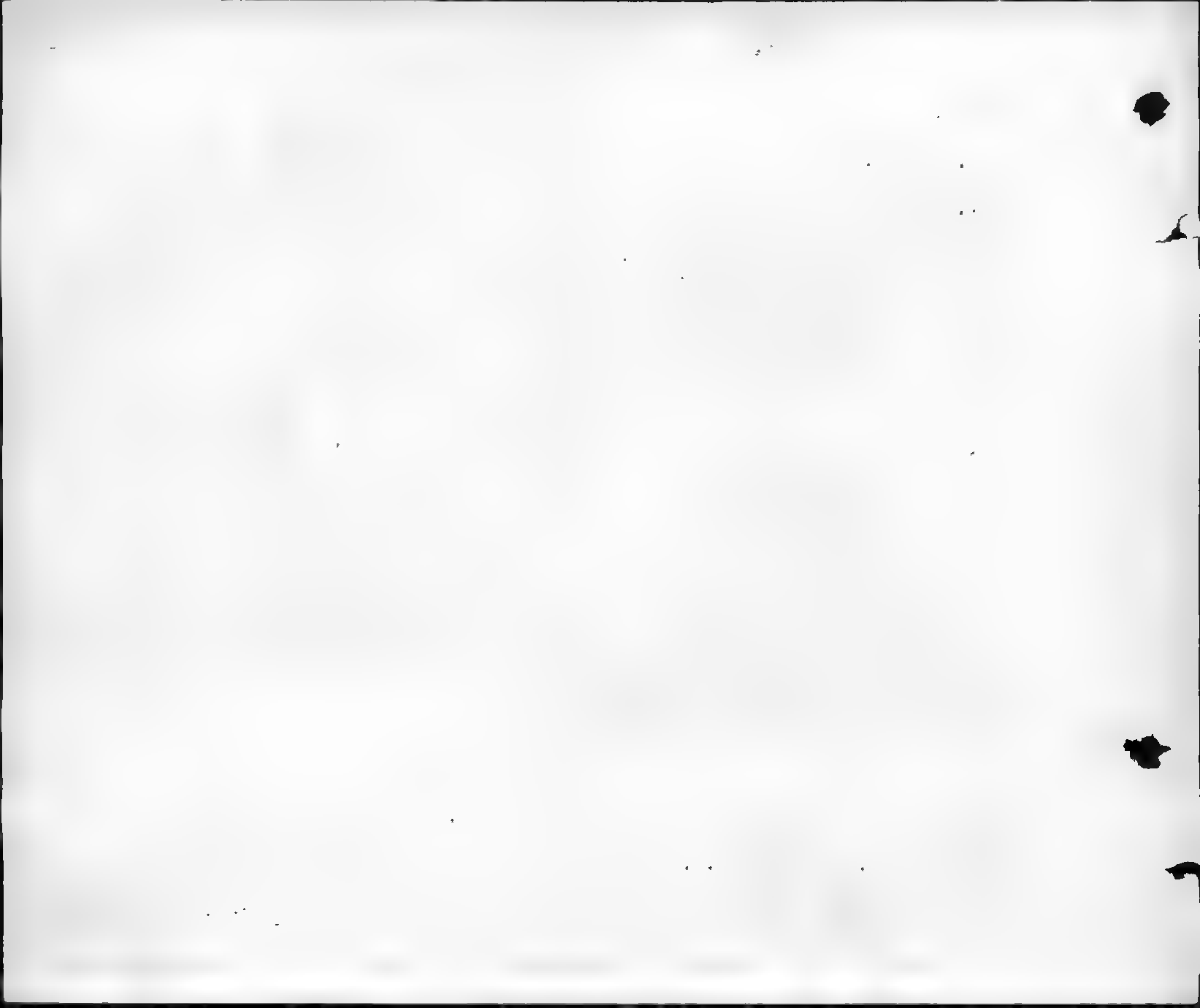
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8944
CERTIFICATE OF DEATH

10063

Reg. Dist. No. 32

| | | | | | | | |
|--|---------------------------------|---|--|---|--|---|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore County MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived (if institution, residence before admission) a. STATE MARYLAND b. COUNTY ANN ARUNDEL | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland | | | | c. LENGTH OF STAY IN 1b RURAL Rt#6 BOX 291 PASADENA | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) JAMES First | | Middle V. | | Last TYNAN | | 4 DATE OF DEATH Month 8 Day 28 Year 1960 | |
| 5 SEX MALE | 6 COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8 DATE OF BIRTH 3-23-91 | | 9 AGE (In years last birthday) 69 yrs | IF UNDER 1 YEAR Months Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) NEW YORK | | 12 CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME JAMES TYNAN | | | | 14 MOTHER'S MAIDEN NAME BRIDGETT LAWLER | | | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES | | 16 SOCIAL SECURITY NO. UNKNOWN | | INFORMANT Address Hospital Records, Mt. Wilson State Hospital | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) FAR ADVANCED PULMONARY TUBERCULOSIS DOX DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 1 YEAR | | | | | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____ | | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from 7-28-1960 to 8-28-1960 that I last saw the deceased alive on 8-28-1960 and that death occurred at 1:30 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE William Newcomer | | M.D. | | ADDRESS (Street, city or town, state) Mt. Wilson, Maryland | | DATE SIGNED _____ | |
| PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent | | | | | | | |
| 22a BURIAL, CREMATION, REMOVAL (Specify) | | 22b DATE THEREOF | | 22c NAME OF CEMETERY OR CREMATORY | | 22d LOCATION (City, town or county) (State) | |
| Buried Sept. 2, 1960 | | | | St. Stephen's | | Baltimore, Md. | |
| 23 FUNERAL DIRECTOR'S SIGNATURE Frank J. Newell | | | | ADDRESS Pikesville | | 24a REC'D BY REGISTRAR DATE SEP 8 '60 | |
| | | | | | | 24b REGISTRAR'S SIGNATURE William S. Kenna | |

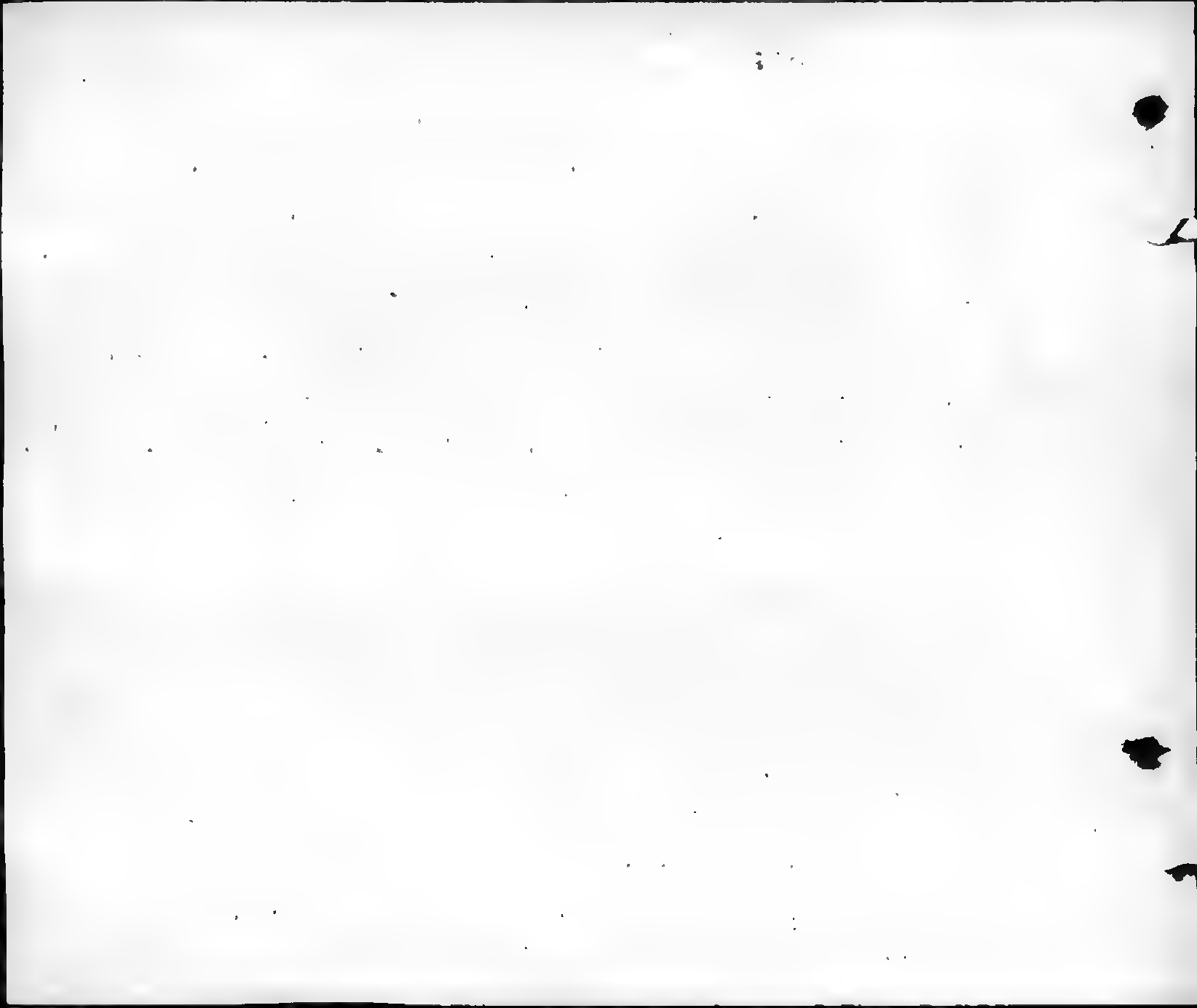
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



0.8917

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/58



8946

0.8918

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be placed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

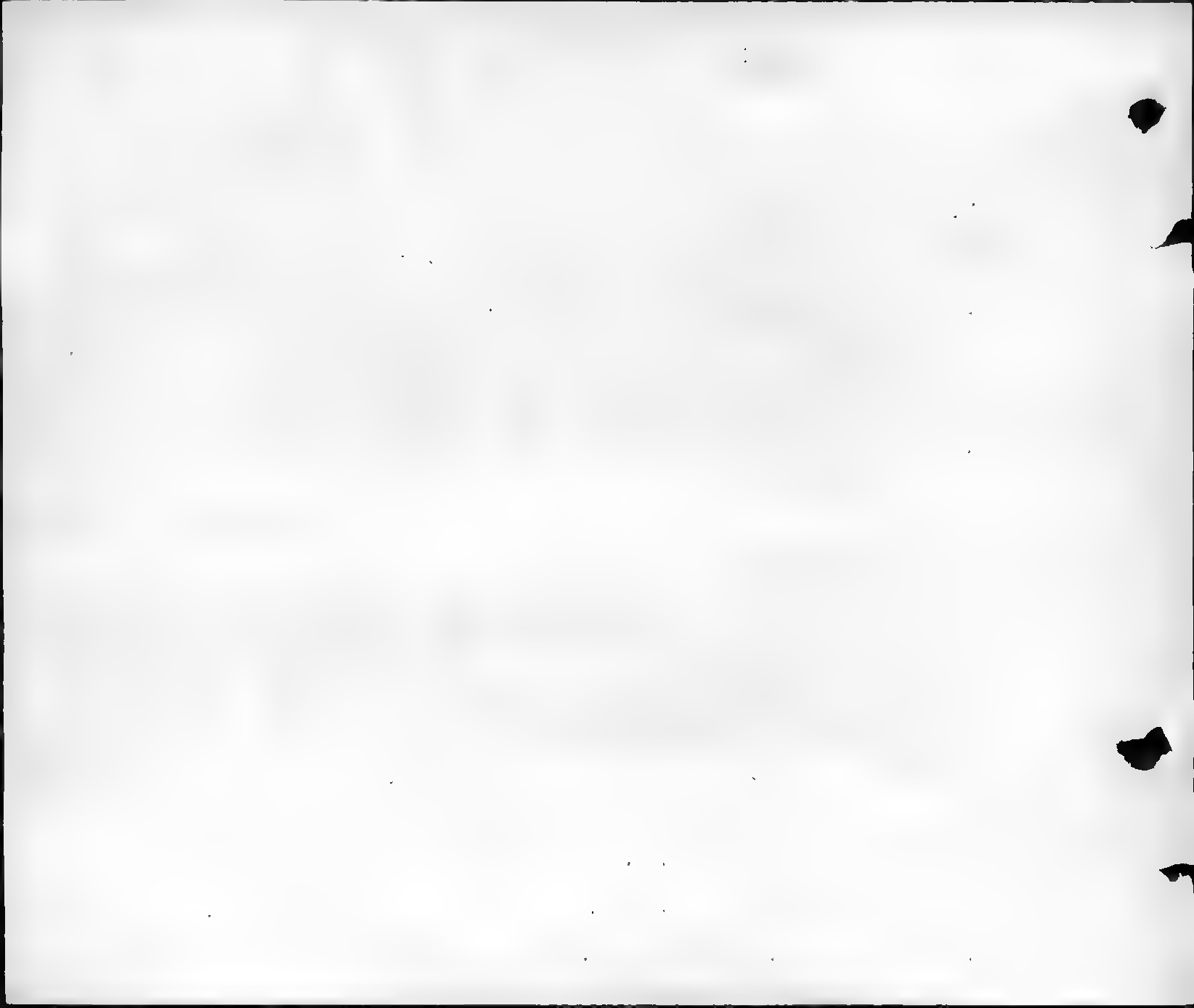
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Page 4

VR A15
15M 8750



1

MD

8947

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08919
Reg. Dist. No.

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Mass.</u> b. COUNTY <u>V</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chatam</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INST. TOL. ON <u>College Manor</u> | | d. STREET ADDRESS <u>RFD #1 137 B. Chatam</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>B.</u> Last <u>Van Dusen</u> | | 4. DATE OF DEATH Month <u>Aug.</u> Day <u>22</u> Year <u>1960</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 19, 1878</u> |
| 9. AGE (In years last birthday) <u>81</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>England</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Harry Clavel</u> | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Perrin</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>at funeral home</u> | | Address <u>Columbia Heights</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>471X Bronchopneumonia</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized & cerebral arteriosclerosis</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>7-10 days</u> |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>None</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> m. <u>19</u> p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u> | 20f. (City or town) (County) (State) <u>None</u> |
| 21. I certify that I attended the deceased from <u>1/12/42</u> to <u>8/15/60</u> , that I last saw the deceased alive on <u>8/15/60</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Ernest C. Brown, Jr.</u> M.D. | | ADDRESS (Street, city or town, state) <u>1101 N. Calvert St.</u> | |
| PHYSICIAN'S NAME (Type) <u>Ernest C. Brown, Jr., M.D.</u> | | DATE SIGNED <u>8/23/60</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Valleau Cemetery</u> | | 22b. DATE THEREOF <u>8-23-60</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Ridgewood, New Jersey</u> | | 22d. LOCATION (City, town, or county) (State) <u>New Jersey</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Towson, Inc., 1050 York Road, Towson</u> | | 24a. REC'D BY REGISTRAR DATE <u>AUG 24 '60</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



1 4 PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. VS A15 (4) 15M 9/58

Item 16

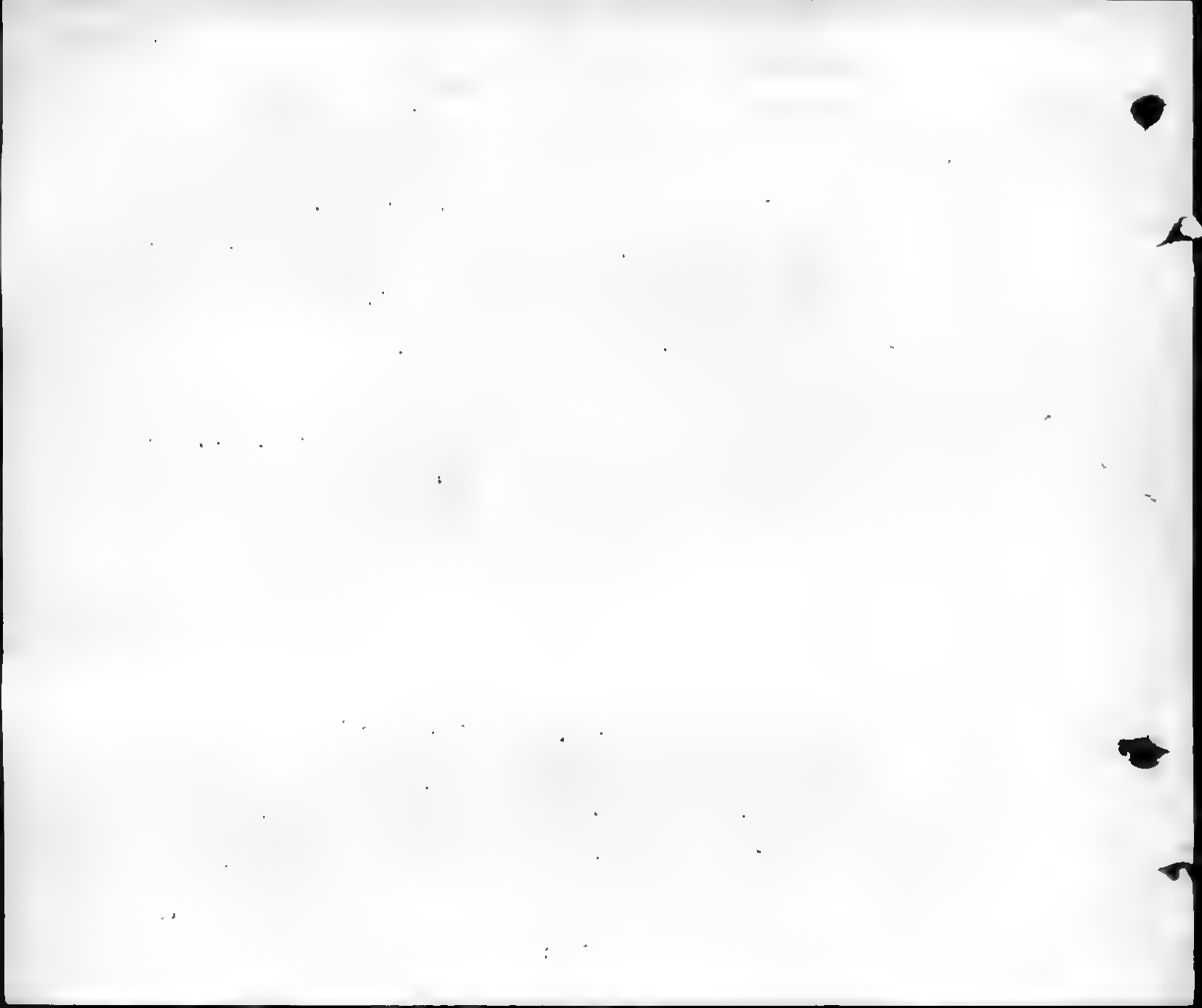
8948

CERTIFICATE OF DEATH

08920

Reg. Dist. No.

| | | | |
|---|------------------------------------|---|---|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Catonsville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Summit Nursing Home | | d. STREET ADDRESS 2027 E. 31st St. | |
| 3 NAME OF DECEASED (Type or print) First HARRY Middle F. Last WAGNER | | 4. DATE OF DEATH Month August Day 5 Year 1960 | |
| 5 SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 16, 1892 |
| 9 AGE (In years last birthday) 68 yrs | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Clerk Ret. | | 10b. KIND OF BUSINESS OR INDUSTRY DRUG Co | |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Martin Wagner | | 14. MOTHER'S MAIDEN NAME Not Known | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes. W.W. I | | 16. SOCIAL SECURITY NO Unknown | |
| 17. INFORMANT Robert Wagner-2027 E. 31st St. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 331X Cerebral Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | | 20f. (City or town) (County) (State) 8/5/60 | |
| 21. I certify that I attended the deceased from 8/1/1960 to 8/5/60 , that I last saw the deceased alive on 8/1/1960 , and that death occurred at 445R M, from the causes and on the date stated above. | | DATE SIGNED 8/8/60 | |
| ACTUAL SIGNATURE W.E. McCreth M.D. | | ADDRESS (Street, city or town, state) 1303 Frederick Rd Catonsville, Md. | |
| PHYSICIAN'S NAME (Type) W.E. McCreth | | DATE SIGNED 8/8/60 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 8-9-60 | 22c. NAME OF CEMETERY OR CREMATORY Meadowridge Cem. | 22d. LOCATION (City, town, or county) (State) Elkridge, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home, Catonsville, Md. | | 24a. REC'D BY REGISTRAR AUG 11 '60 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the following information: Name of deceased, date and place of birth, date and place of death, cause of death, and any other information that may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

8949

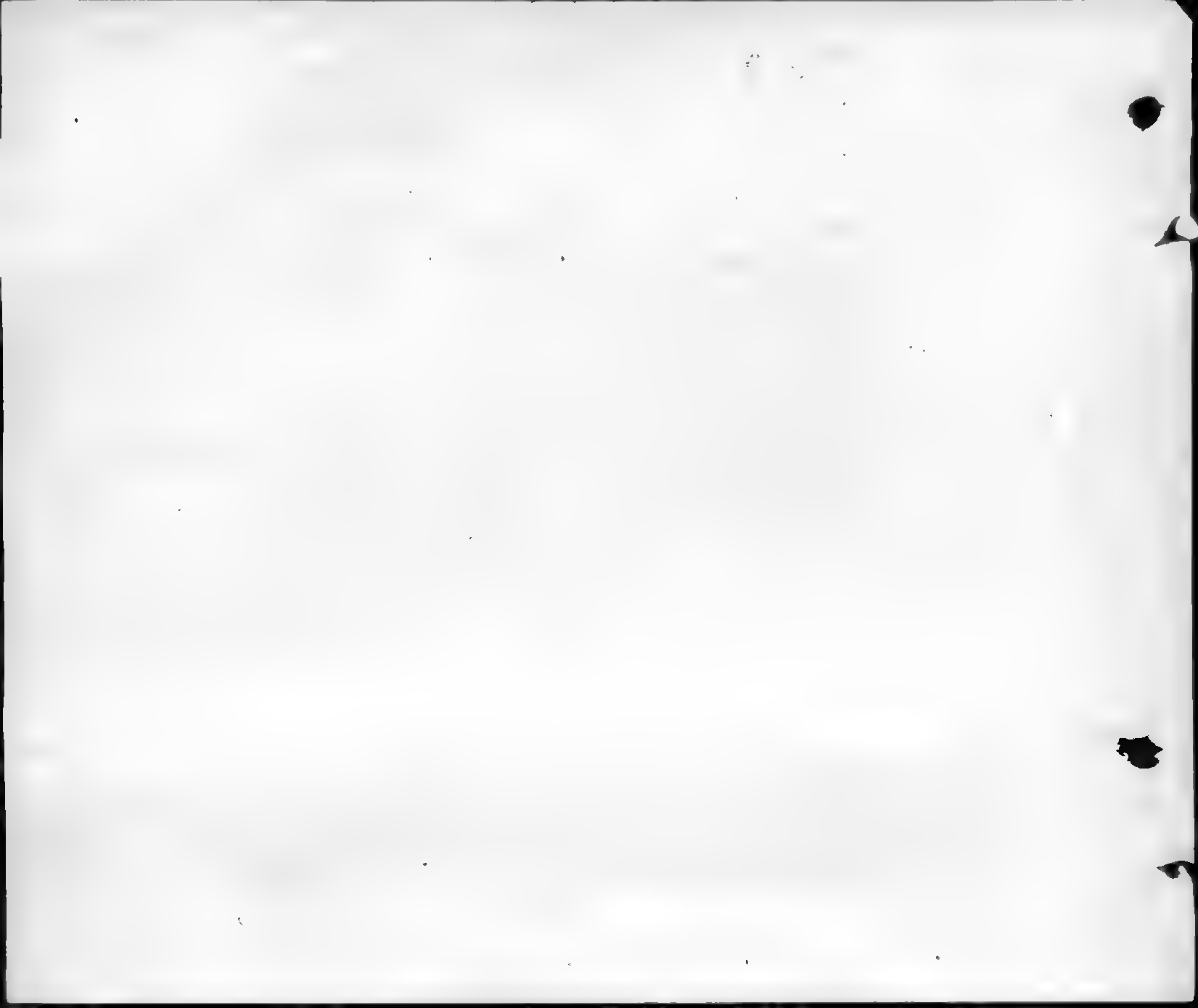
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08921

| | | | |
|--|-------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>7 yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Catonsville Nursing Home</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>1411 Annapolis St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Arthur F. Walker</u> | | 4. DATE OF DEATH Month <u>August</u> Day <u>25</u> Year <u>1960</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept. 23, 1905</u> |
| 9. AGE (In years last birthday) <u>54 yrs</u> | | 10. IF UNDER 1 YEAR Months <u>1</u> Days <u>2</u> Hours <u>1</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Copper works</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>New York, New York</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Walker</u> | | 14. MOTHER'S MAIDEN NAME <u>Christian</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO <u>none</u> | |
| 17. INFORMANT <u>Mary Christian</u> | | Address <u>1212 Annapolis St. Balto 24</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>159X Gasto Intestine Denovize</u> DUE TO (b) <u>Cancer of GI tract</u> DUE TO (c) <u>lying cause last.</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cancer</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month <u>10</u> Day <u>20</u> Year <u>1960</u> Hour <u>a. m.</u> <u>8:25</u> p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10/20</u> 19 <u>60</u> , to <u>8/25</u> 19 <u>60</u> , that (I) (we) lost the deceased alive on <u>8/25</u> 19 <u>60</u> , and that death occurred at <u>10:30</u> M. from the causes and on the date stated above | | | |
| 22a. SIGNATURE <u>Cliff Ratliff</u> | | 22b. DATE <u>8/25/60</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF</u> | | 22d. ADDRESS <u>4605 Edmondson</u> | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Aug 27, 1960</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Schwartz' Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran</u> | | 25a. REC'D BY REGISTRAR <u>Aug 29 '60</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur F. Walker</u> | | 25c. ADDRESS <u>3000 E. Baltimore St.</u> | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the attending physician and completely filled in by the funeral director. Pages 3 and 4 should be filled with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

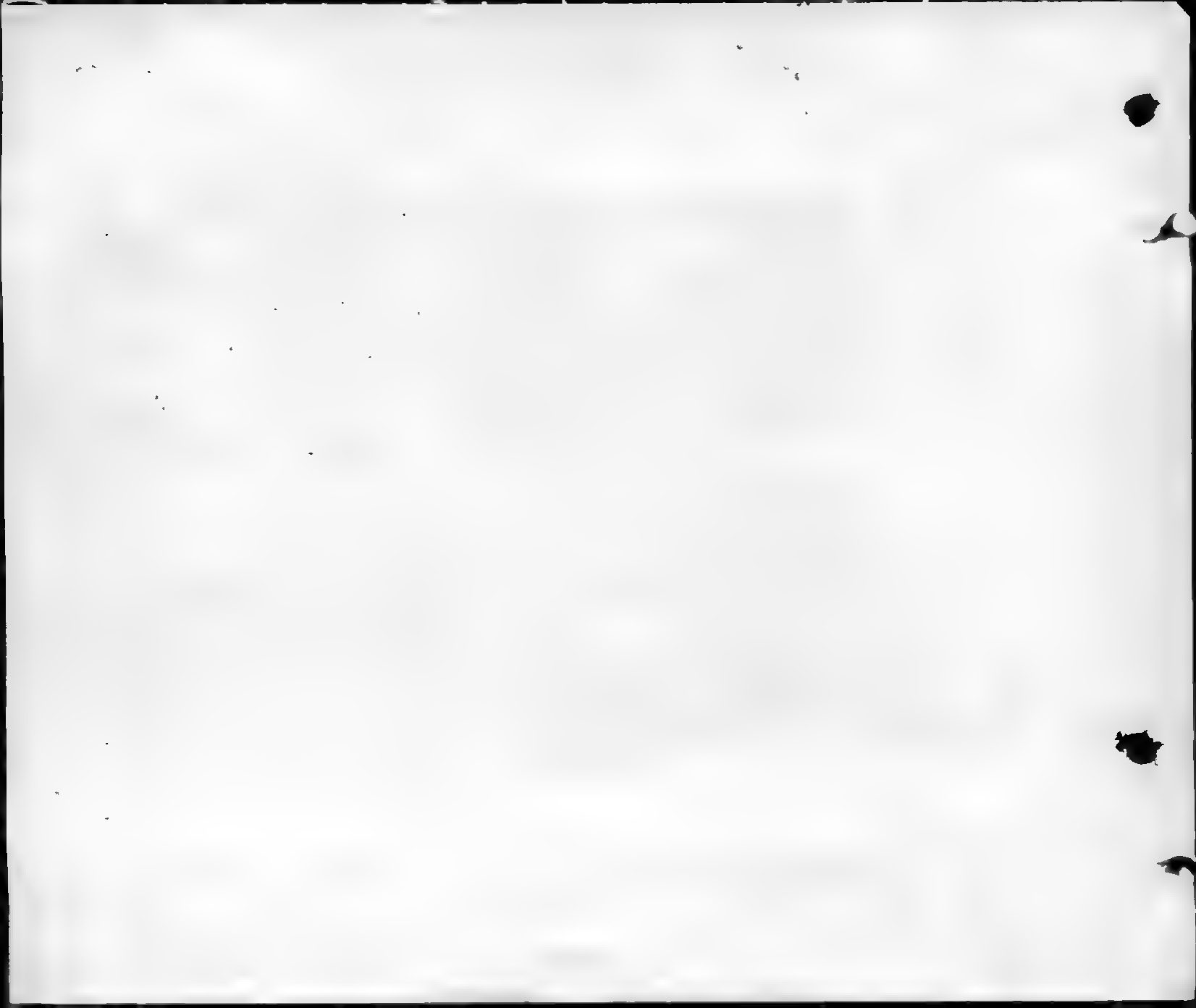
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8950 Item 3 File No. 277 12-21-60 et

08922

| | | | |
|---|---------------------------|--|---------------------------------------|
| 1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> | | c. LENGTH OF STAY IN 1b <u>Catonsville</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5623 Edmondson Ave</u> | | d. STREET ADDRESS <u>5623 Edmondson Ave</u> | |
| 3 NAME OF DECEASED (Type or print) <u>Margaret B. Waring</u> | | 4. DATE OF DEATH <u>Aug. 25/60</u> | |
| 5 SEX <u>Female</u> | 6 COLOR OR RACE <u>W.</u> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> | 8 DATE OF BIRTH <u>April 23, 1909</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Cleveland Dairy Balto. Md.</u> | |
| 11 BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | 12 C ITIZEN OF WHAT COUNTRY? | |
| 13 FATHER'S NAME <u>Rat Leroy Barclay</u> | | 14 MOTHER'S MAIDEN NAME <u>Clara H. Conway</u> | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16 SOCIAL SECURITY NO. <u>Mr. Geo. W. Wessel, 11 Ridge Pl. Cat.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Arteriosclerosis -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u>Diabetes - mild - controlled by diet.</u> | | | |
| 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21 I certify that (I) (this hospital) attended the deceased from <u>July 6, 1960</u> to <u>Aug. 26, 1960</u> , that (I) (we) last saw the deceased alive on <u>Aug. 26, 1960</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Chas. Norton Jr.</u> | | 22b. DATE SIGNED <u>8/27/60</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>J. CHAS. NORTON, JR. M.D.</u> | | 22d. ADDRESS <u>5550 Balto. Nat'l Pike, 28.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>8/29/60</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Balto. 29. Md</u> | | 23d. LOCATION (City, town, or county) (State) | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Walter F. W. 4101 Edmondson Ave.</u> | | 25a. REC'D BY REGISTRAR <u>DATE AUG 29 '60</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | | | |

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MEDICAL CERTIFICATION



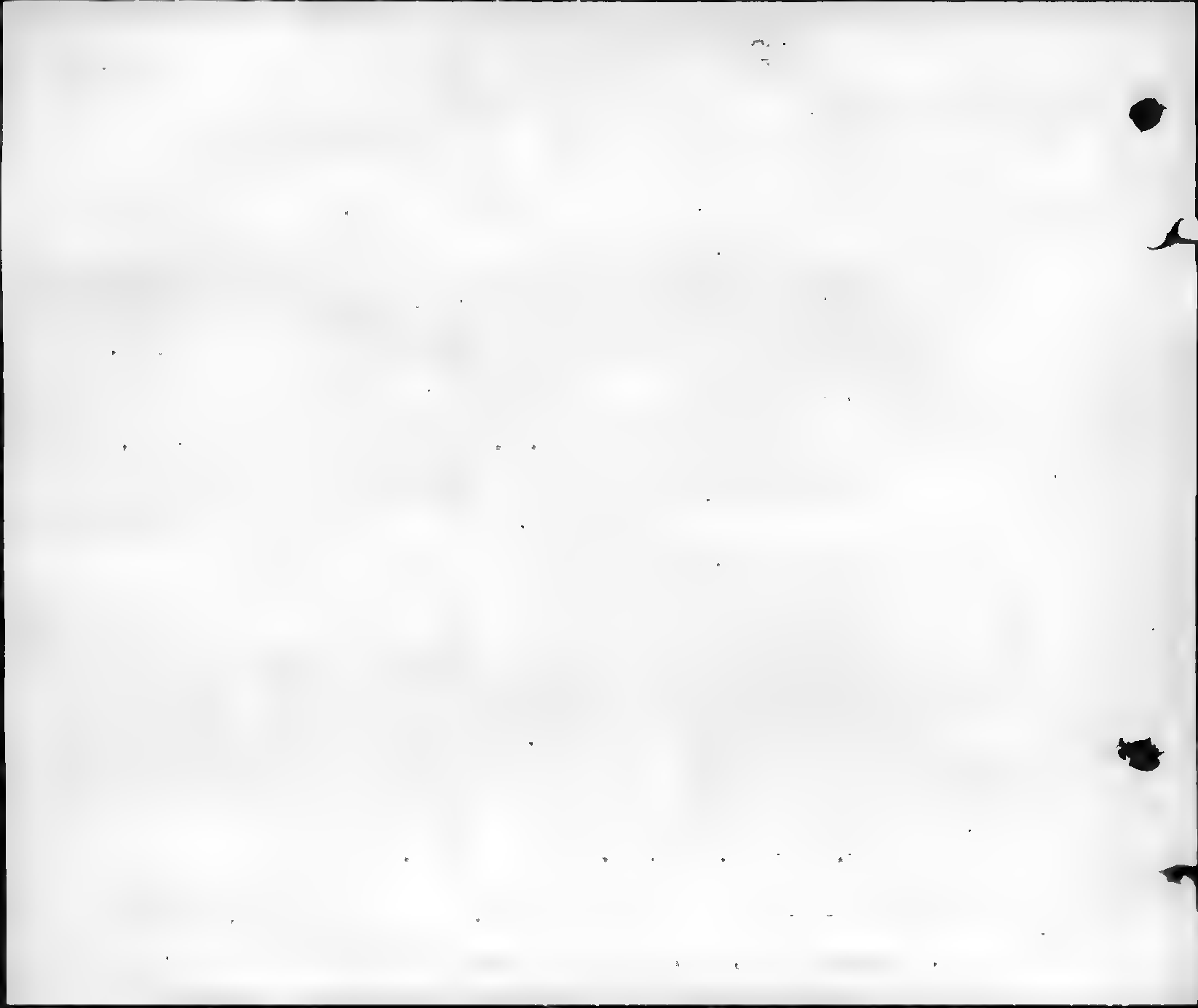
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director; page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A11 (4)
15M 9-59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8951
CERTIFICATE OF DEATH

08923

| | | | |
|---|------------------------------|--|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Armacost Nursing Home | | 2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS Homewood Apts. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First Carrie Middle Brooks Last Warner | | 4. DATE OF DEATH Month August Day 26 Year 19 60 | |
| 5 SEX Female | 6 COLOR OR RACE White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH February 4, 1870 |
| 9 AGE (In years last birthday) 90 yrs | | IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min 0 IF UNDER 24 HRS: Months 0 Days 0 Hours 0 Min 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | 11 BIRTHPLACE (State or foreign country) Kentucky |
| 12 CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Thomas E.O. Brooks | |
| 14. MOTHER'S MAIDEN NAME Angie Pegg | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Dr. C. Gardner Warner 7115 Bristol Rd. Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Atherosclerotic degenerative C.V. Disease DUE TO Coronary sclerosis. Ch. Myocardial Damage. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Congestive heart failure DUE TO Senility (c) Senility | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (i) (this hospital) attended the deceased from 7/1/47 to 26 Aug 1960 , that (i) (we) last saw the deceased alive on 26 Aug 1960 , and that death occurred at 5:30 PM , from the causes (and on the date stated above) | | | |
| 22a. SIGNATURE Joseph E. Muse, Jr. | | 22b. DATE SIGNED 26 Aug 1960 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. Joseph E. Muse, Jr. | | 22d. ADDRESS 2725 N. Charles Street | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 23b. DATE THEREOF 8-29-60 | |
| 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem. | | 23d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons, Inc. | | 25a. REC'D BY REGISTRAR AUG 29 '60 | |
| ADDRESS 1900 Eutaw Place | | 25b. REGISTRAR'S SIGNATURE Orlando L. Kenna | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8952 Item 9 8952-9-1-70 at

CERTIFICATE OF DEATH

Reg. Dist. **8924**

| | | | |
|---|----------------------------------|--|--------------------------------------|
| 1 PLACE OF DEATH a. COUNTY MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | |
| e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | f. STREET ADDRESS g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Du... d... d... S... | | 4 DATE OF DEATH Month Day Year 12 16 1960 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5-16-1901 |
| 9. AGE (In years last birthday) 75 1/4 yrs | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | |
| 11. BIRTHPLACE (State or foreign country) Illinois, U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Henry Milton Watts | | 14. MOTHER'S MAIDEN NAME Hannah Dilworth | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give date of service) No | | 16. SOCIAL SECURITY NO. 012-02-0002 | |
| 17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> = 31X DUE TO (b) <u>Arteriosclerosis, generalized</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) <u>generalized</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH 3 weeks 2 years | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Oct 4, 1956 to Aug 12, 1960, that I last saw the deceased alive on August 10, 1960, and that death occurred at 3:45 PM from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Clarence E. McWilliams</u> M.D. | | DATE SIGNED <u>August 13, 1960</u> | |
| PHYSICIAN'S NAME (Type) <u>Clarence E. McWilliams</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | |
| 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | 24a. REC'D BY REGISTRAR | |
| ADDRESS | | DATE <u>AUG 16 '60</u> | |
| 24b. REGISTRAR'S SIGNATURE | | 25. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

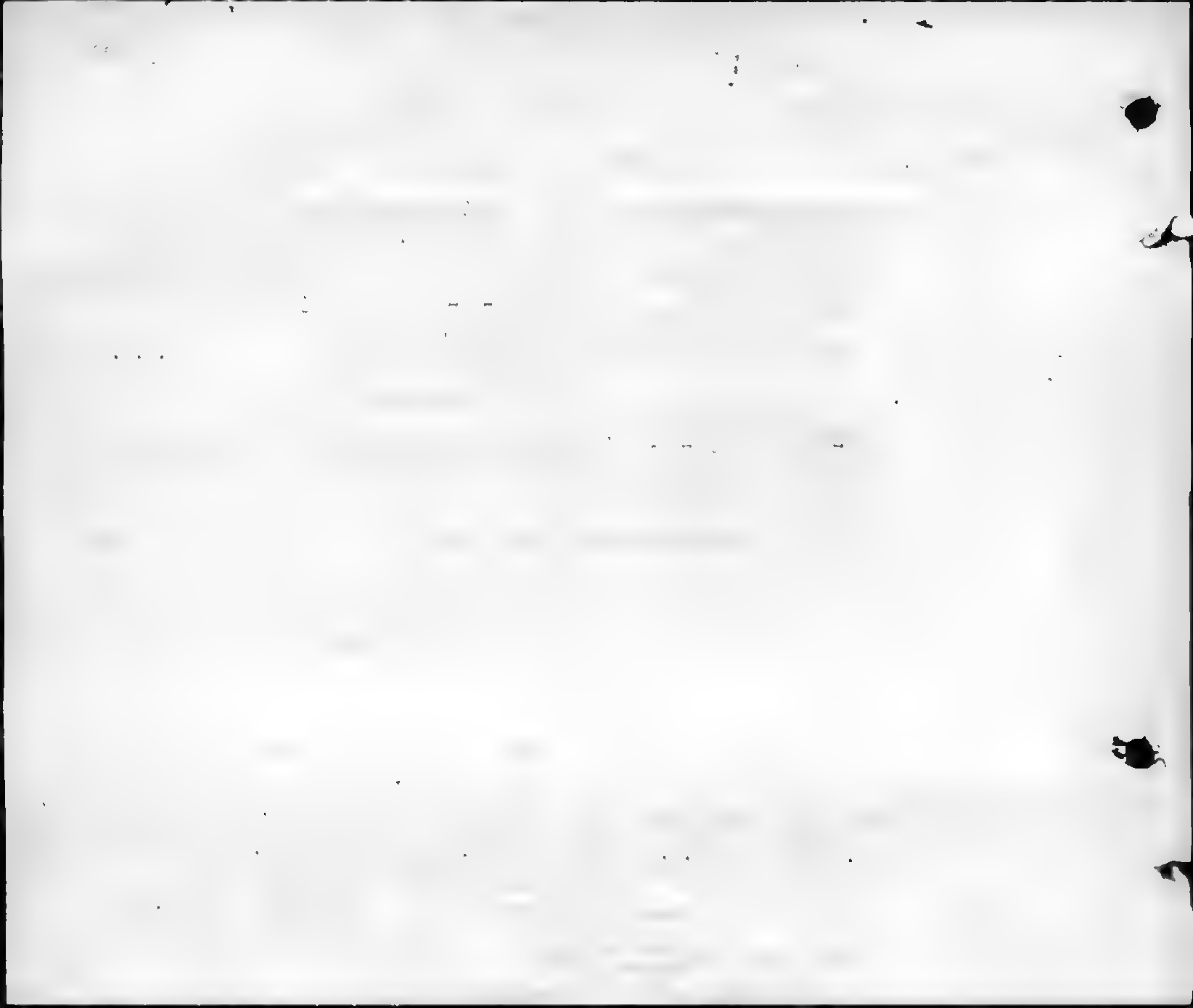
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8953

08925

| | | | |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | c. LENGTH OF STAY IN 1b 152 DAYS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL | | e. STREET ADDRESS 3947 SINCLAIR LANE | |
| 3. NAME OF DECEASED (Type or print) First WILLIAM Middle GURNEY Last SR. WATTS | | 4. DATE OF DEATH Month AUGUST Day 23 Year 19 60 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4-28-26 |
| 9. AGE (in years or birthday) 34 yrs | | 10. IF UNDER 1 YEAR F UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE MAN | | 10b. KIND OF BUSINESS OR INDUSTRY BALTIMORE PRESS | |
| 11. BIRTHPLACE (State or foreign country) Wilmington NORTH CAROLINA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JUDGE T. WATTS | | 14. MOTHER'S MAIDEN NAME ETTA RUSSELL | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-11 | | 16. SOCIAL SECURITY NO 238-26-6667 | |
| 17. INFORMANT CLIN REC VAH BALTO MD FT HOWARD DIVISION | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ADENOCARCINOMA, LEFT LUNG DUE TO (c) | | | |
| INTERVAL BETWEEN ONSET AND DEATH RECENT 9 MONTHS | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 24, 1960 , to August 23, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 23, 1960 , and that death occurred at 3:30 P.M. , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>Frederick S. Donaldson</i> | | 22b. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION | |
| 22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D. | | 22d. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 8/26/60 | |
| 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL | | 23d. LOCATION (City, town or county) (State) BALTIMORE MARYLAND | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Schimunek Funeral Home | | 25a. REC'D BY REGISTRAR AUG 25 '60 | |
| ADDRESS 3331 Brohms Lane Baltimore 13 Md | | 25b. REGISTRAR'S SIGNATURE <i>William S. Kline</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate has been signed by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: A copy of this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08926

8954

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) <input checked="" type="checkbox"/> a. STATE <u>Md.</u> b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Pines 16 Tustling Ave</u> | | e. STREET ADDRESS <u>2510 Arundel Ave.</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Anna Margaret Wehnert</u> | | 4. DATE OF DEATH Month Day Year <u>Aug. 28/60</u> | |
| 5. SEX <u>F.</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb. 6, 1887</u> |
| 9. AGE (in years last birthday) <u>72</u> | | 10. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>H.W.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>John Kamm</u> | | 14. MOTHER'S MARRIED NAME <u>Johanna</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>Mr. Peter Siewicz, Rivers Beach Md</u> | |
| 17. INFORMANT Address <u>Mrs. Peter Siewicz, Rivers Beach Md</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease and metastases</u> <u>420.1</u> DUE TO <u>from cancer of uterus.</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last (b) DUE TO (c) | |
| PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9-10-54</u> to <u>8-28-60</u> , that (I) (we) last saw the deceased alive on <u>8-16-60</u> , and that death occurred at <u>8-28-60</u> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Harry S. Gimbel</u> | | 22b. DATE SIGNED <u>8/29/60</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>HARRY S. GIMBEL</u> | | 22d. ADDRESS <u>605 Arundel Ave - Baltimore, Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF <u>Aug 31/60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Landon Park</u> | 23d. LOCATION (City, town, or county) (State) <u>Baltimore, 29, Md</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Witko & Co. 4101 Edmondson Ave</u> | | 25a. REC'D BY REGISTRAR <u>DATE AUG 30 '60</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Knecht</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the physician or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



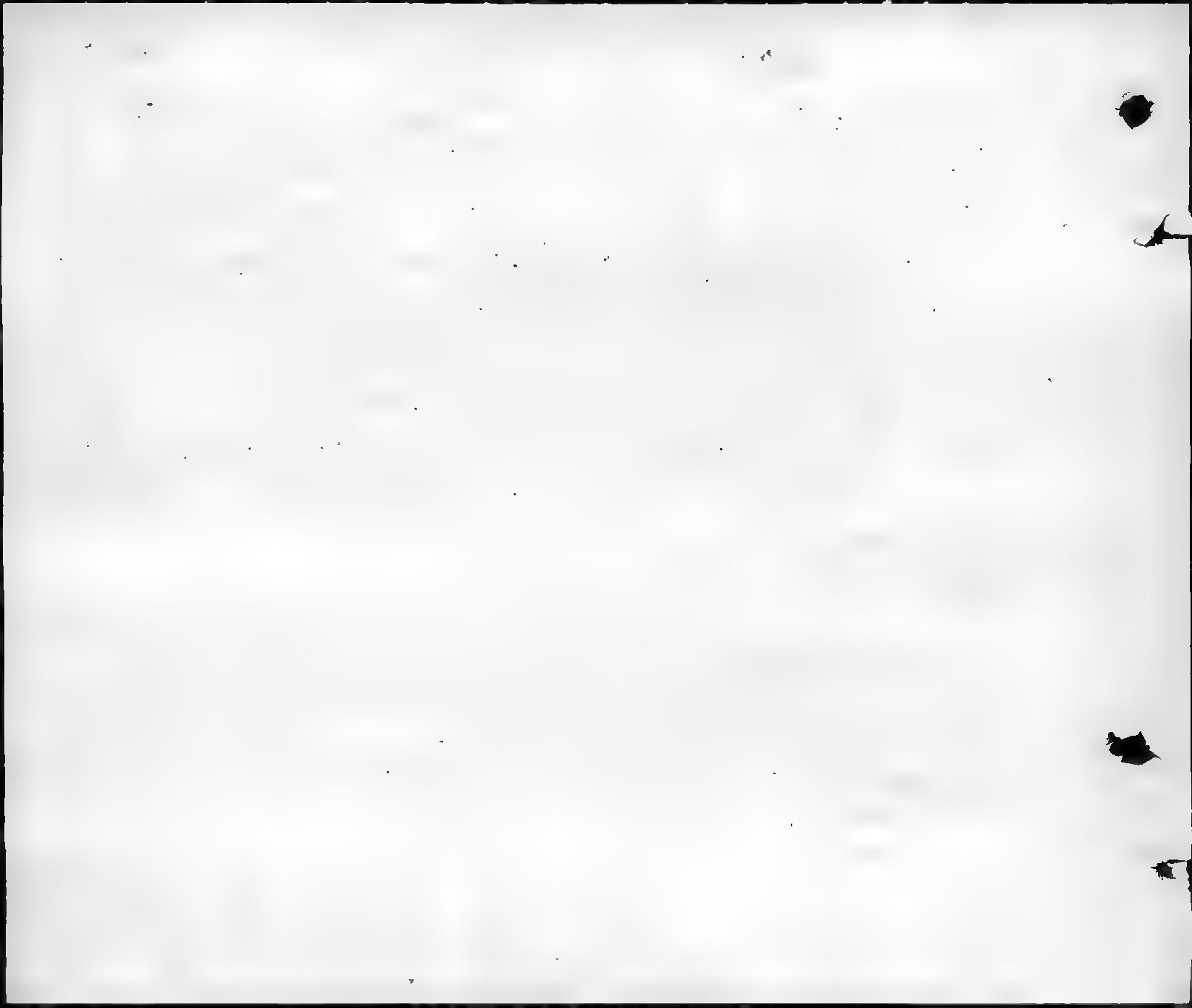
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8955 CERTIFICATE OF DEATH 08927

| | | | |
|---|--|--|--|
| 1 PLACE OF DEATH a COUNTY <i>Balto.</i> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a STATE <i>Md</i> b COUNTY <i>Balto</i> | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonville</i> | | c LENGTH OF STAY IN 1b <i>Catonville</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Caton Ridge Home</i> | | e STREET ADDRESS <i>141 Sanford Ave</i> | |
| 3 NAME OF DECEASED (Type or print) <i>George W. Weinkam</i> | | f DATE OF DEATH Month <i>Aug</i> Day <i>26</i> Year <i>1960</i> | |
| 5 SEX <i>Male</i> | 6 COLOR OR RACE <i>W</i> | 7a MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 7b WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <i>9/20/85</i> |
| 9 AGE (in years last birthday) <i>74</i> yrs | | 10 IF UNDER 1 YEAR Months Days Hours 11 IF UNDER 24 HRS. M n | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>clerk</i> | | 10b KIND OF BUSINESS OR INDUSTRY <i>ret.</i> | |
| 11 BIRTHPLACE (State or foreign country) <i>Md.</i> | | 12 CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13 FATHER'S NAME <i>unknown</i> | | 14 MOTHER'S MAIDEN NAME <i>unknown</i> | |
| 15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> | | 16. SOCIAL SECURITY NO <i>212 10 3242</i> | |
| 17 INFORMANT <i>Mrs Floris Gettier</i> | | Address | |
| 18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c)] | | INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs.</i> | |
| PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral arteriosclerosis</i> DUE TO (c) <i>Arteriosclerotic Cardio Vasc. disease</i> | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c TIME OF INJURY Month, Day Year Hour a. m. p. m. | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f (City or town) (County) (State) |
| 21 I certify that (I) (this hospital) attended the deceased from <i>Feb. 28, 1960</i> to <i>August 26, 1960</i> , that (I) (we) last saw the deceased give an <i>Aug 26, 1960</i> , and that death occurred at <i>5:00 PM</i> , from the causes and on the date stated above. | | | |
| 22a SIGNATURE <i>Harry K. Knipp</i> | | 22b DATE SIGNED <i>8-27-60</i> | |
| 22c PHYSICIAN'S NAME (Type) <i>HARRY K. KNIPP M.D.</i> | | 22d ADDRESS <i>4116 Edmondson Ave #29</i> | |
| 23a BURIAL, CREMATION, REMOVAL Specify | 23b DATE THEREOF <i>Buried Aug 29, 60</i> | 23c NAME OF CEMETERY OR CREMATORY <i>London Park</i> | 23d LOCATION (City, town, or county) (State) <i>Balto. Md</i> |
| 24a FUNERAL DIRECTOR'S SIGNATURE <i>Marshall + Son</i> | | 24b ADDRESS <i>28</i> | |
| 25a REC'D BY REGISTRAR DATE <i>AUG 30 '60</i> | | 25b REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8801

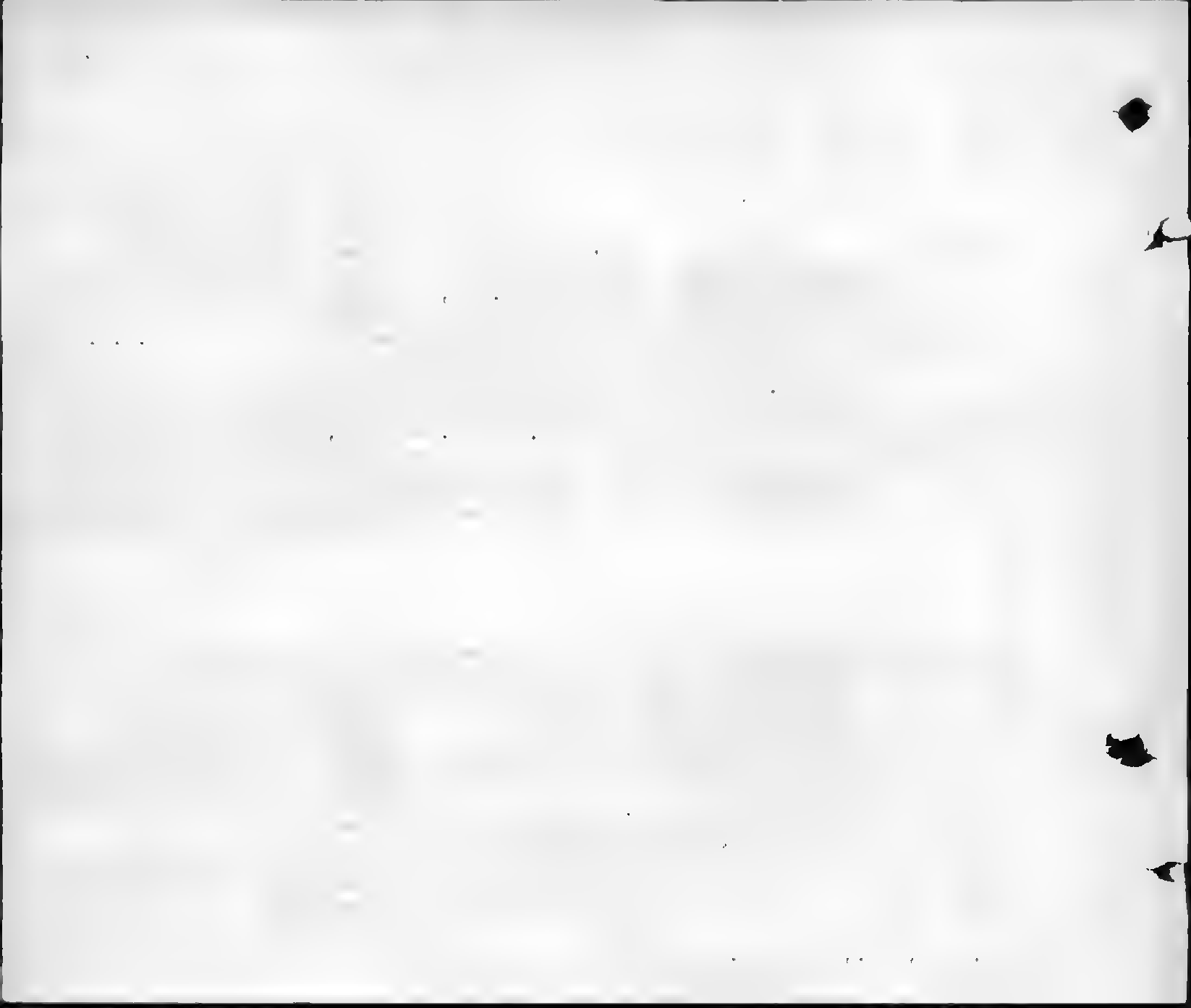
CERTIFICATE OF DEATH

Reg. Dist. No.

08928

| | | | | | | | |
|---|----------------------------------|--|--|--|---|--|------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus 27 | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus 27 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4501 Poplar Avenue | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Clarence E. Willard | | | | 4. DATE OF DEATH Month August Day 22 Year 1960 | | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 20, 1884 | | 9. AGE (In years birth day) 75 yrs | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME George T. Willard | | | | 14. MOTHER'S MAIDEN NAME Mary Helen Harding | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO | | 17. INFORMANT Mrs. Edna J. Harding Address 4501 Poplar Avenue | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 4-2-60 DUE TO CEREBRAL ARTERIO SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE DUE TO ARTERIO SCLEROSIS (c) ARTERIO SCLEROSIS | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 DAY 14 YEARS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BRONCHIAL ASTHMA | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from 21 Nov. 1941 to 22 Aug 1960 that I last saw the deceased alive on 22 Aug 1960 , and that death occurred at 9:45 A.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Edward F. Milan | | | | DATE SIGNED 682 Washington Bldg | | | |
| PHYSICIAN'S NAME (Type) EDWARD F. MILAN, M.D. | | | | BALTIMORE - 30, MD. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 8-27-60 | | 22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery | | 22d. LOCATION (City, town, or county) (State) Baltimore | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street | | | | 24a. REC'D BY REGISTRAR DATE AUG 25 '60 | | 24b. REGISTRAR'S SIGNATURE C. J. S. Kline | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: A copy of this certificate is to be retained for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

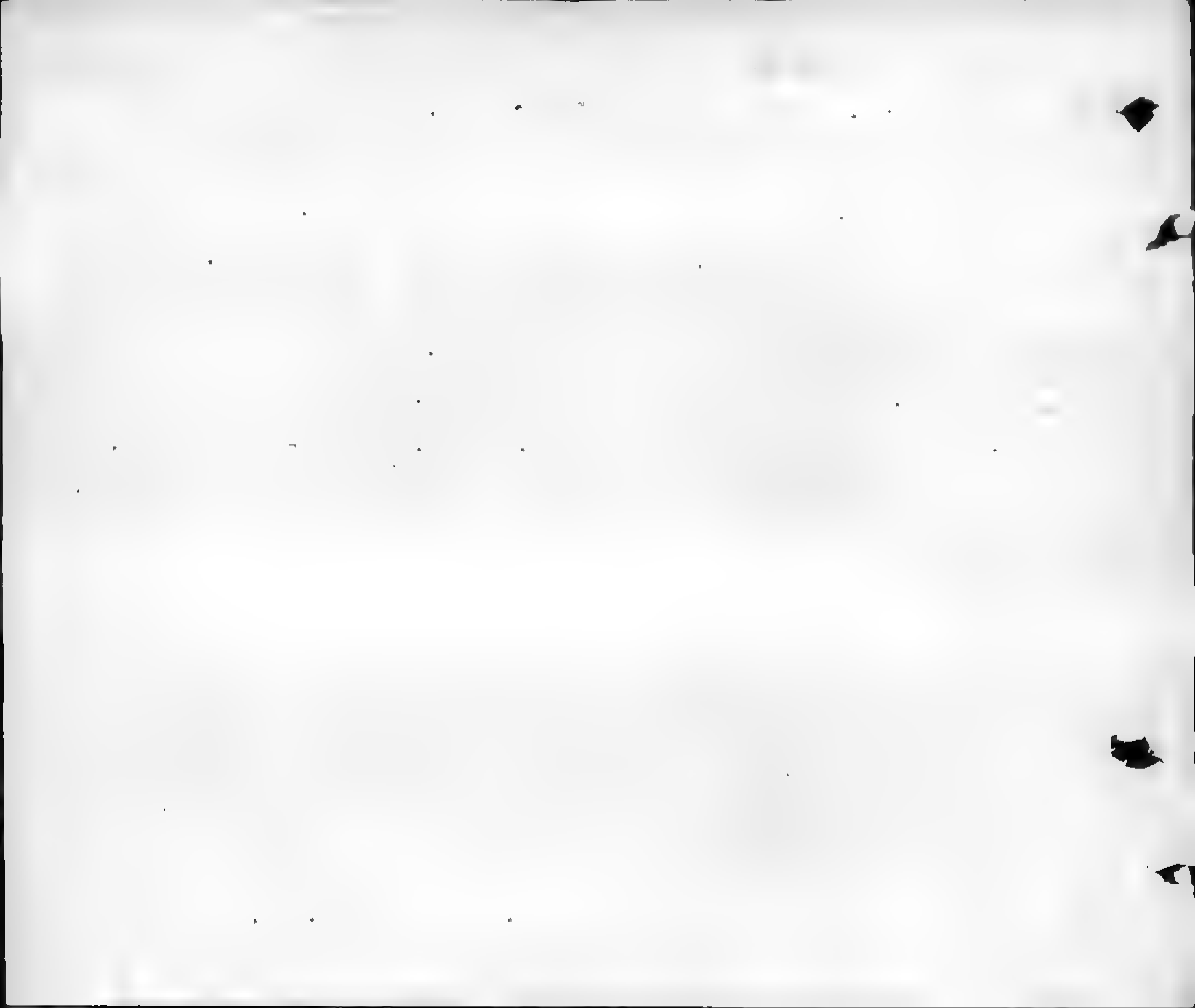
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8956

CERTIFICATE OF DEATH

08929

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Balto. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevenson | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevenson | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wiltonwood Rd. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First DOROTHY D. Middle WILLIAMS Last WILLIAMS | | 4. DATE OF DEATH Month Aug. Day 8 Year 1960 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 5, 1896 |
| 9. AGE (In years last birthday) 64 yrs | | 10. IF UNDER 1 YEAR Months 2 Days 14 Hours 5 Min 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Schoolteacher (rtd) | | 10b. KIND OF BUSINESS OR INDUSTRY Education | |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Robert L. Dryden | | 14. MOTHER'S MAIDEN NAME Marion Wetherill | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO no | |
| 17. INFORMANT Mr. James E. Williams - Stevenson, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MEGASTASIS DUE TO " Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost Aggravated by Lung Cancer (b) " (c) Carcinoma of the Lung PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from March 15 to June 8 , 19 60 , that (I) (we) last saw the deceased alive on 1-27 , 19 60 , and that death occurred at 8-10 AM, from the causes and on the date stated above | | | |
| 22a. SIGNATURE William L. Fearing | | 22b. DATE 8-10-60 | |
| 22c. PHYSICIAN'S NAME (Type) WILLIAM L. FEARING | | 22d. ADDRESS 3025 Belair Road | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8/11/60 | |
| 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem. | | 23d. LOCATION (City town or county) (State) Balto., Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickner & Sons - Balto. | | 25a. REC'D BY REGISTRAR DATE AUG 11 '60 | |
| 25b. REGISTRAR'S SIGNATURE Charles E. Hume | | | |



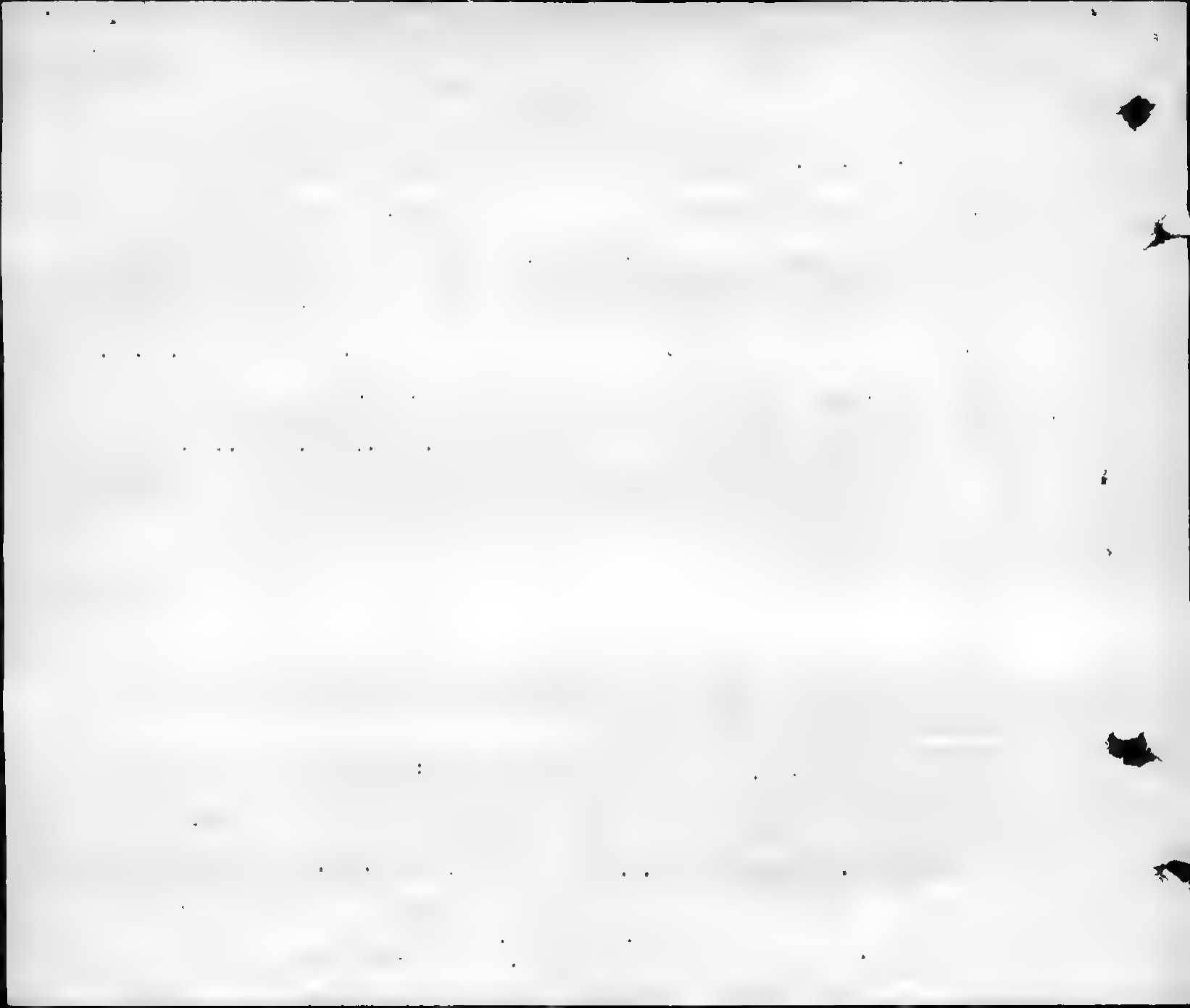
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8957

08930

| | | | | | | | |
|---|--|---|---|---|---|--|--|
| 1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard, Md.</u> 6 Days c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u> | | | | 2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>812 Bentalou Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3 NAME OF DECEASED (Type or print) First <u>MANLEY</u> Middle <u>---</u> Last <u>WILLIAMS</u> | | | 4. DATE OF DEATH Month <u>August</u> Day <u>10</u> Year <u>1960</u> | | | | |
| 5 SEX <u>Male</u> | | 6 COLOR OR RACE <u>Negro</u> | | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 8. DATE OF BIRTH <u>May 1, 1910</u> | | 9 AGE (in years last birthday) <u>50</u> yrs IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min _____ IF UNDER 24 HRS: _____ | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Printing</u> | | 11. BIRTHPLACE (State or foreign country) <u>Hartsville, S. Carolina</u> | | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | | | | | |
| 13 FATHER'S NAME <u>Ephron Williams</u> | | | 14. MOTHER'S MAIDEN NAME <u>Mary Richardson</u> | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW II</u> | | 16 SOCIAL SECURITY NO _____ | | 17. INFORMANT Address <u>Veterans Adm. Hosp. BALTO. 18, MD., Ft. Howard Division</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF COLON</u> <u>153.8</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost _____ (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____ | | | | |
| 20c. TIME OF INJURY Month _____ Day _____ Year _____ Hour _____ a. m. _____ p. m. _____ | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | | | |
| 20f. (City or town) _____ | | (County) _____ | | (State) _____ | | | |
| 21 I certify that (this hospital) attended the deceased from <u>August 4, 1960</u> , to <u>August 10, 1960</u> , that (we) last saw the deceased alive on <u>Aug 10, 1960</u> , and that death occurred at <u>3:15 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>George C. McElpatrick</u> M.D. | | | ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22b. DATE SIGNED <u>8/10/60</u> | | |
| 22c. PHYSICIAN'S NAME (Type) <u>GEORGE C. MC ELPATRICK, M.D.</u> | | | 22d. ADDRESS <u>VAH, BALTO. MD. - FT HOWARD DIVISION</u> | | | | |
| 23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>8/15/60</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u> | | | |
| 23d. LOCATION (City, town, or county) (State) <u>Baltimore 28, Maryland</u> | | | | | | | |
| 24 FUNERAL DIRECTOR'S SIGNATURE <u>Arlington S. Phillips</u> | | | 25a. REC'D BY REGISTRAR <u>1800 N. Monroe St. Baltimore 17, Md.</u> | | 25b. REGISTRAR'S SIGNATURE <u>DATE AUG 15 '60</u> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the attending physician and completely filled in by the funeral director. This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

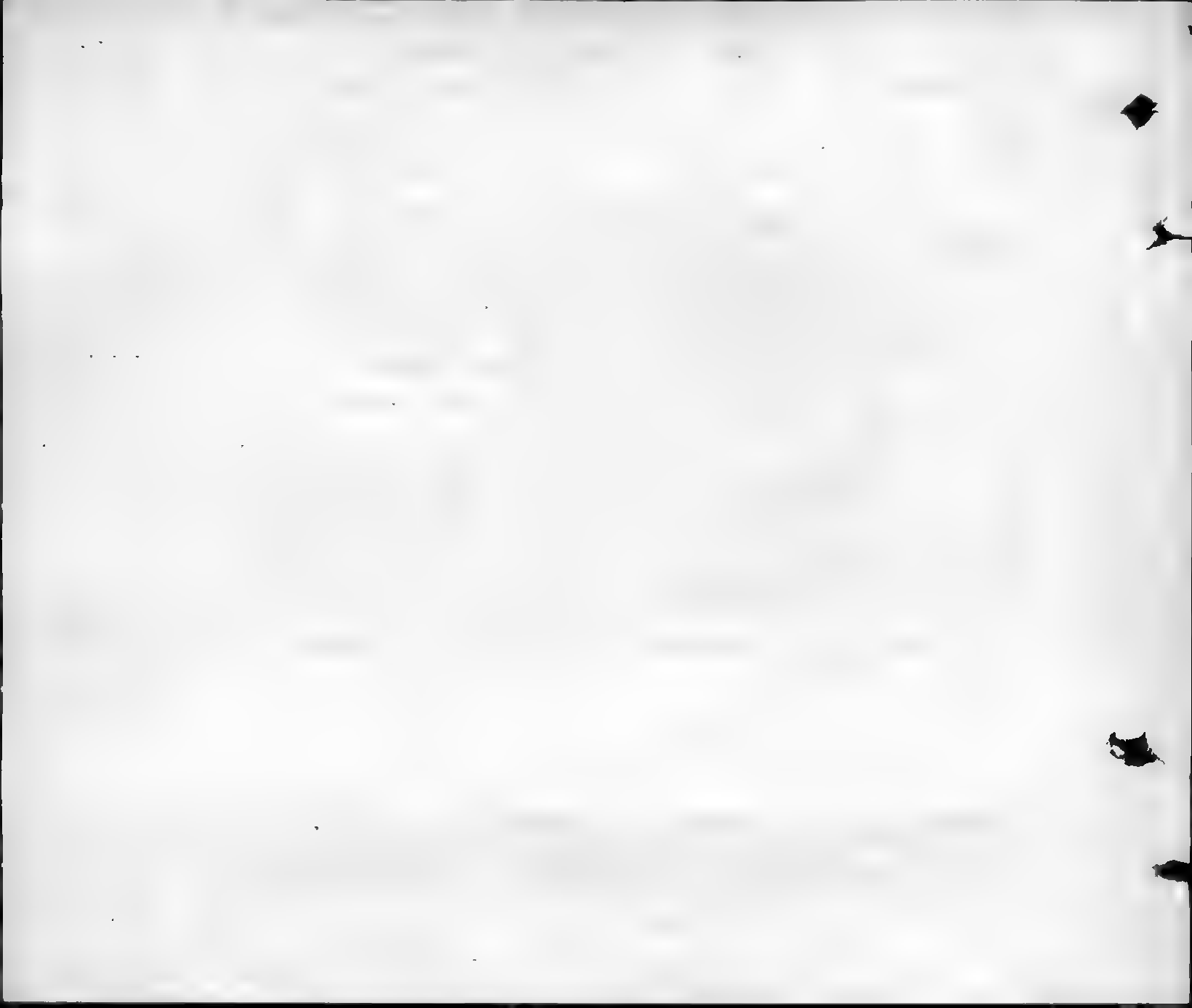
8958

CERTIFICATE OF DEATH

Reg. Dist. No. 08931

| | | | |
|--|---------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Loreley</u> | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. STREET ADDRESS <u>Loreley</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Williams</u> Last <u>Williams</u> | | 4. DATE OF DEATH Month <u>Aug.</u> Day <u>17</u> Year <u>1960</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>Colored</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb. 12, 1872</u> |
| 9. AGE (In years last birthday) <u>88</u> yrs | | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Distillery</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Thomas Williams</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary E. Johnson</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>no</u> (If yes, give year or dates of service) | | 16. SOCIAL SECURITY NO. <u>18-01-7834</u> | |
| 17. INFORMANT <u>Campbell Williams, Loreley Rd., White Marsh, Md.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 4-20-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>4-20-0</u> DUE TO (c) <u>4-20-0</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2-yr</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Feb. 1</u> , 19 <u>59</u> , to <u>Aug 17</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Aug 17</u> , 19 <u>60</u> , and that death occurred at <u>8:30 p.m.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Fred O. Hodus</u> M.D. | | ADDRESS (Street, city or town, state) <u>Edgewood Maryland.</u> DATE SIGNED | |
| PHYSICIAN'S NAME (Type) <u>Fred O. Hodus</u> | | Edgewood Maryland. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>Aug 23, 1960</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Ashbury</u> | 22d. LOCATION (City, town, or county) (State) <u>Loreley Balto., Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. M. Brown</u> | | 24a. REC'D BY REGISTRAR <u>AUG 24 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Howard K. M. Brown</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08932

| | | | | | | | |
|---|------------------------------|---|-------------------------------------|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE | | c. LENGTH OF STAY IN 1b 6 MONTHS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME | | | | d. STREET ADDRESS 106 W UNIVERSITY PKWY. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First NETA Middle BURNHAM Last WILLIAMSON | | | | 4. DATE OF DEATH Month AUG Day 8 Year 1960 | | | |
| 5. SEX FE | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1-5-1883 | 9. AGE (In years last birthday) 77 yrs | IF UNDER 1 YEAR Months Days Hours Min | IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME WALTER COOK BURNHAM | | | | 14. MOTHER'S MAIDEN NAME HATTIE C. ROBERTS | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 217-16-6053 | | 17. INFORMANT Name Frank L. Smith Address Cockeysville | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO (b) Arterio Sclerotic Cardio Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) 6 months | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month Day, Year Hour o m p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1-17 , 19 60 , to 8-8 , 19 60 , that (I) (we) last saw the deceased alive on 8-8 , 19 60 , and that death occurred at 9A :M, from the causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE Walter T. Kees | | M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22b. DATE SIGNED 8/8/60 | | | |
| 22c. PHYSICIAN'S NAME (Type) WALTER T. KEES | | 22d. ADDRESS COCKEYSVILLE, MD | | | | | |
| 23a. BURIAL, CREMATION, or other disposal (Specify) BURIAL | | 23b. DATE THEREOF 8-11-60 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | 23d. LOCATION (City, town, or county) (State) Baltimore | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street | | | | 25a. REC'D BY REGISTRAR DATE AUG 10 '60 | | 25b. REGISTRAR'S SIGNATURE William L. Kenna | |



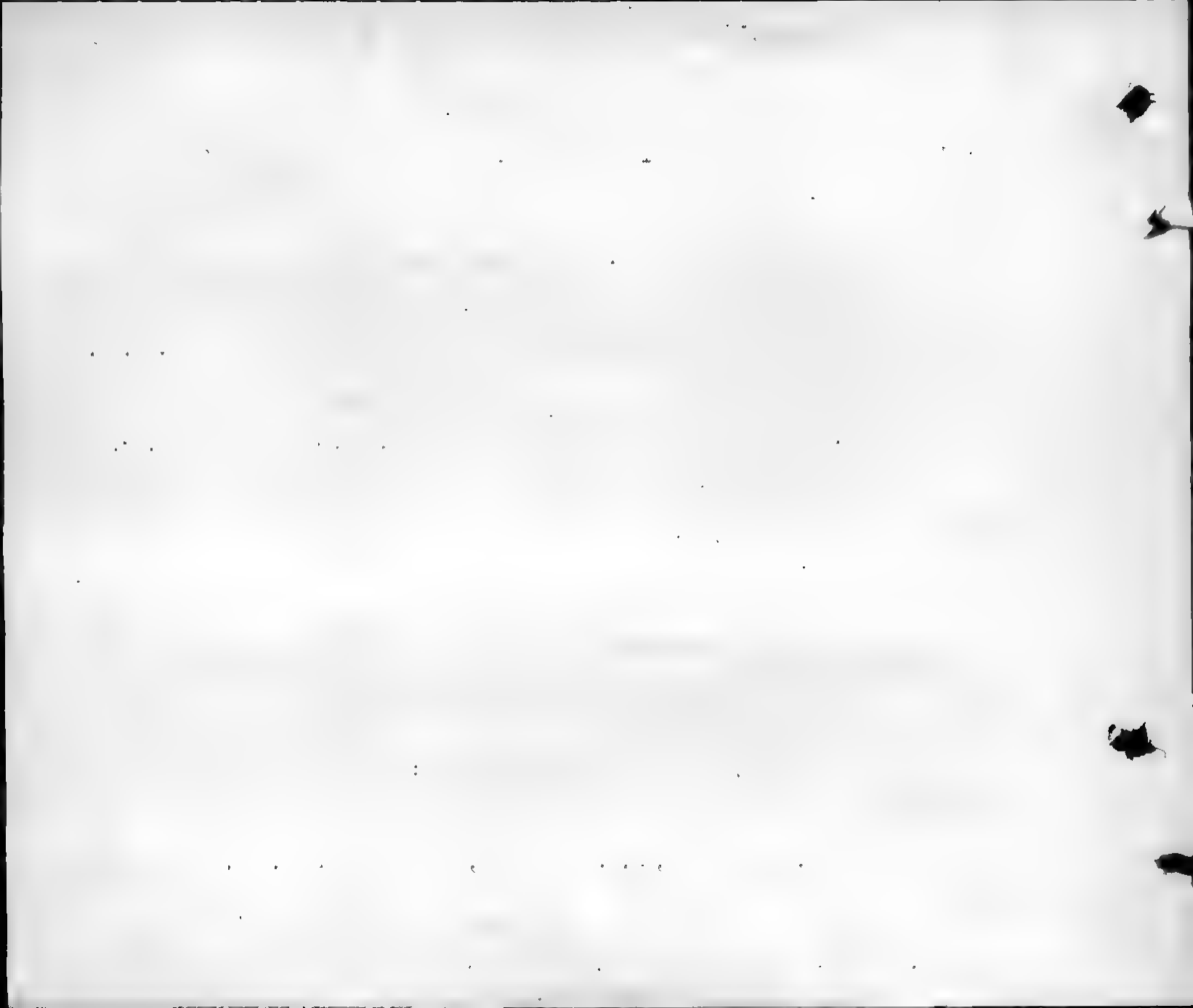
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08933

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | | | c. LENGTH OF STAY IN 1b 101 Days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital | | | | e. STREET ADDRESS 1416 Woodcliff Avenue | | | |
| 3. NAME OF DECEASED (Type or print) First ANDREW Middle J. Last WINDFELDER | | | | 4. DATE OF DEATH Month August Day 2 Year 1960 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH January 7, 1916 | |
| 9. AGE (In years last birthday) 44 yrs | | 10. IF UNDER 1 YEAR Months 4 Days 4 Hours 4 Min. | | 11. IF UNDER 24 HRS Months 4 Days 4 Hours 4 Min. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock Keeper | | | | 10b. KIND OF BUSINESS OR INDUSTRY Wholesale Drugs | | | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | |
| 13. FATHER'S NAME George Windfelder | | | | 14. MOTHER'S MAIDEN NAME Sophia Kaltenback | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes (If yes, give year or dates of service) WW II | | | | 16. SOCIAL SECURITY NO 220-03-9404 | | | |
| 17. INFORMANT Clinical Records, VAH, Baltimore 18, Md. Ft. Howard | | | | Address Division | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MALIGNANT MELANOMA | | | | | | | 6 YEARS |
| Condit ons, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | 6 MONTHS |
| (b) METASTASIS TO THE RIGHT TEMPORAL LOBE OF THE BRAIN | | | | | | | 6 MONTHS |
| (c) PYELONEPHRITIS | | | | | | | 3 WEEKS |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that X (this hospital) attended the deceased from April 23, 1960 to August 2, 1960 , that X (we) last saw the deceased alive on August 2, 1960 , and that death occurred at A. M. from the causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE Walter J. Pijanowski | | | | 22b. ADDRESS VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION | | | |
| 22c. PHYSICIAN'S NAME (Type) WALTER J. PIJANOWSKI, M.D. | | | | 22d. ADDRESS VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION | | | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) Burial | | | | 23b. DATE THEREOF 8-6-60 | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery | | | | 23d. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE George A. Farley, Frederick And Shady Nook Aves. | | | | 25a. REC'D BY REGISTRAR AUG 8 '60 | | | |
| 25b. REGISTRAR'S SIGNATURE Arthur L. Thomas | | | | 25c. REGISTRAR'S SIGNATURE Arthur L. Thomas | | | |

Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate has been signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8961

CERTIFICATE OF DEATH

Reg. Dist. No. 08934

| | | | | | | | |
|---|----------------------------------|---|--|--|--|--|---------|
| 1. PLACE OF DEATH a. COUNTY <u>LANDOWNE -27- MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admiss on) a. STATE <u>MARYLAND</u> b. COUNTY <u>11111</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2334 MONUMENTAL RD</u> | | | | d. STREET ADDRESS <u>2334 MONUMENTAL RD</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN</u> <u>Wischhusen</u> | | | | 4. DATE OF DEATH Month Day Year <u>AUG</u> <u>19</u> <u>1960</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>AUG-18-1888</u> | 9. AGE (In years last birthday) <u>72</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min | IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MARITIME GUARD</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u> | | 11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>?</u> | | | | 14. MOTHER'S MAIDEN NAME <u>?</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>217-05-2316</u> | | 17. INFORMANT <u>RECORDS.</u> | | | Address |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>overly</u> DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 hr 15 min</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>overly</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. p. <u>19</u> p. m. | | | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> NOT while <input type="checkbox"/> of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>November 19, 59</u> to <u>Aug. 19, 1960</u> , that I last saw the deceased alive on <u>August 19, 1960</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Florian P. Nadolski</u> | | | | ADDRESS (Street, city or town, state) <u>2703 HANCOCK FERRY RD</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Florian P. Nadolski</u> | | | | DATE SIGNED <u>Baltimore 27, Md</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>8-22-60</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>GLEN HAVEN CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. Kacharskas</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>AUG 23 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>William E. Krasner</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1 4 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8962

CERTIFICATE OF DEATH

Reg. Dist. No.

08935

| | | | |
|--|--------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u> | | c. LENGTH OF STAY IN 1b <u>7 yrs.</u> X | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cheryl Ave</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>H</u> Last <u>Wooden Sr.</u> | | 4. DATE OF DEATH Month <u>Aug</u> Day <u>16</u> Year <u>1960</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan 30 1885</u> |
| 9. AGE (In years, low birth date) <u>75</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Edge Arch.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Balto Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>William Wooden</u> | | 14. MOTHER'S MAIDEN NAME <u>Capitolia ? Roberson</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>220-20-7988</u> | |
| 17. INFORMANT <u>Corrinne C. Wooden</u> | | Address <u>Cheryl Ave</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Broncho-Pneumonia</u> 422.1 DUE TO <u>Arteriosclerotic Cardiovascular Dis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <u>8 yrs.</u> (c) <u>36 hrs.</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchial Asthma</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>8/16 1960</u> | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>8/14</u> , 19 <u>60</u> , to <u>8/16</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>8/16</u> , 19 <u>60</u> , and that death occurred at <u>5:28</u> P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Clifford F. Hudson</u> | | DATE SIGNED <u>FORK, MD.</u> | |
| PHYSICIAN'S NAME (Type) <u>CLIFFORD F. HUDSON</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>AUG 19 1960</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>ST STEPHEN'S CEM</u> | 22d. LOCATION (City, town, or county) (State) <u>BRAD SHAW MD.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Doppel Box</u> | | ADDRESS <u>7110 BELAIR RD.</u> | |
| 24a. REC'D BY REGISTRAR <u>AUG 18 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u> | |

CERTIFICATE OF DEATH

1982

02132

1. Name of Deceased: John Doe

2. Sex: Male

3. Race: White

4. Date of Birth: 10/15/1925

5. Date of Death: 11/10/1982

6. Place of Birth: New York, NY

7. Usual Residence: 123 Main St, New York, NY

8. Cause of Death: Heart Disease

9. Manner of Death: Natural

10. Signature of Physician: [Signature]

11. Signature of Medical Examiner: [Signature]

12. Signature of Registrar: [Signature]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8963

CERTIFICATE OF DEATH

Reg. Dist. No. 08936

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|--|-------------------------------|--|--------------------------------------|---|--|--|--|
| 1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4 | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1901 Glen Ridge Road | | | | d. STREET ADDRESS 1901 Glen Ridge Road | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First Marian Middle B. Last Wright | | 4. DATE OF DEATH | | Month August Day 10 Year 1960 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 4, 1912 | | 9. AGE (In years last birthday) yrs. 48 | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Francis A. Reck | | | | 14. MOTHER'S MAIDEN NAME Katherine Hartman | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 214-01-1142 | | 17. INFORMANT Address Thelma Younger, 1901 Glen Ridge Road | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO 420.01 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis DUE TO (c) Generalized arteriosclerosis | | | | | | INTERVAL BETWEEN ONSET AND DEATH Sudden death in sleep. Unknown. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Thrombosis | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Sept. 17, 1953 , to Aug. 10, 1960 , that I last saw the deceased alive on Aug. 5, 1960 , and that death occurred at 8 A. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 East Read St. DATE SIGNED Aug. 11, 1960 | | | | | | | |
| ACTUAL SIGNATURE Edward F. Cotter M.D. | | 6 East Read Street | | | | | |
| PHYSICIAN'S NAME (Type) Edward F. Cotter, M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, or other disposition (Specify) BURIAL | | 22b. DATE THEREOF 8-13-60 | | 22c. NAME OF CEMETERY OR CREMATORY Moreland Park | | 22d. LOCATION (City, town, or county) (State) Baltimore | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS William Cook, Inc., 1217 St. Paul Street | | | | 24a. REC'D BY REGISTRAR DATE AUG 12 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Hines | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1917

1917

| | | | | | |
|----------------------------|--|------------------------|--|----------------------|--|
| Name of Deceased | | Sex | | Age | |
| John Doe | | Male | | 45 | |
| Residence | | Occupation | | Cause of Death | |
| 123 Main St, Helena, Mont. | | Farmer | | Heart Disease | |
| Date of Death | | Place of Death | | Time of Death | |
| Jan 15, 1917 | | Home | | 10:00 AM | |
| Physician | | Burial | | Interment | |
| Dr. J. H. Smith | | Buried | | Catholic Cemetery | |
| Signature of Physician | | Signature of Registrar | | Signature of Coroner | |
| [Signature] | | [Signature] | | [Signature] | |
| Official Seal | | Official Seal | | Official Seal | |
| [Seal] | | [Seal] | | [Seal] | |

1